

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #230 Film #G385 2/27/67pc

00070

## CERTIFICATE OF DEATH

00070

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gambrills, (rural)</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>North Arundel Hospital</b>		d. STREET ADDRESS <b>Box 133, Gambrills</b>	
3. NAME OF DECEASED (Type or print) <b>Herbert Thomas Allen</b>		4. DATE OF DEATH Month <b>January</b> Day <b>25</b> Year <b>1967</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. <del>NEVER MARRIED</del> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-26-99</b>
9. AGE (In years lost birthday) <b>67</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>27</b>	11. IF UNDER 24 HRS. Hours <b>19</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>construction</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Cleveland, Ohio</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>James Thomas Allen</b>	
14. MOTHER'S MAIDEN NAME <b>Florence May Knott</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes</b> <b>unknown</b>	
16. SOCIAL SECURITY NO. <b>563-22-1655</b>		17. INFORMANT <b>Mrs. Ethel M. Reynolds - same as #2 above</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO <b>ASHD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 3, 1967</b> to <b>Jan 25, 1967</b> that (I) (we) lost saw the deceased alive on <b>Jan 3, 1967</b> , and that death occurred at <b>1 A</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Dr. Joseph Taler</b>		22b. DATE SIGNED <b>Jan 25, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Joseph Taler</b>		22d. ADDRESS <b>95 Aquahart Road, Glen Burnie, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal-Burial</b>	23b. DATE THEREOF <b>1/26/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lakeview Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Cleveland Cuyahoga Ohio</b>
24. FUNERAL DIRECTOR <b>Beverley E. Hopping</b> <b>Hopping Funeral Home</b>		25a. REC'D BY REGISTRAR <b>DATE JAN 27 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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## CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN lb <b>5 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>		d. STREET ADDRESS <b>Nowell Road</b>	
3. NAME OF DECEASED (Type or print) <b>William Francis ATWELL</b>		4. DATE OF DEATH Month <b>January</b> Day <b>16</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 18, 1885</b>
9. AGE (In years last birthday) yrs. <b>81</b>		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>16</b> Hours <b>16</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CONTRACTOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BUILDING</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Robert F Atwell</b>		14. MOTHER'S MAIDEN NAME <b>MINNIE Kirchner</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>215 30 3393</b>	
17. INFORMANT <b>BERNIE A. Ferguson Shadyside Md.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: <b>446X</b> IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO (b) <b>Nephrosclerosis &amp; pyelitis</b> DUE TO (c) <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>3:20 AM</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (not hospital) attended the deceased from <b>Jan. 16, 19 67</b> to <b>Jan. 16, 19 67</b> that (I) (not) saw the deceased alive on <b>Jan. 16, 19 67</b> , and that death occurred at <b>3:20 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Willard F. Smith</b>		22b. DATE SIGNED <b>1/16/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Willard F. Smith, M.D.</b>		22d. ADDRESS <b>Shady Side, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>1-18-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Wood Field</b>		23d. LOCATION (City or Town) (County) (State) <b>Galesville, Md</b>	
24. FUNERAL DIRECTOR <b>HARDESTY F. H. Galesville, Md</b>		25a. REC'D BY REGISTRAR <b>JAN 24 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00072

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena Md</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>OWN Home</u>		d. STREET ADDRESS <u>RT 9 - Box 461</u>	
3. NAME OF DECEASED (Type or print) <u>DAISY ELLEN BAUER</u>		4. DATE OF DEATH <u>1-10-67</u> 19 <u>19</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 23, 1890</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Anne Arundel Co</u>
13. FATHER'S NAME <u>Elsey Bee Wade</u>		14. MOTHER'S MAIDEN NAME <u>Vernie Duval</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Herbert M. Bauer Sr.</u> Address <u>Pasadena Md</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): <u>Congestive Heart Failure</u> 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b): <u>Coronary Failure</u> DUE TO (c): <u>A.C.V.D.</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1958</u> , 19 <u>1958</u> , to <u>1967</u> , 19 <u>1967</u> , that (I) (we) last saw the deceased alive on <u>Dec 19, 1966</u> , and that death occurred at <u>7:35</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert R. Hahn</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>1-19-67</u>
22c. PHYSICIAN'S NAME (Type) <u>Robert R. HAHN</u>		22d. ADDRESS <u>P.O. Box Severna Park</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1/13/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>ELK RIDGE, Md</u>
24. FUNERAL DIRECTOR <u>ITIRIXLEY</u>		ADDRESS <u>Home, Glen Burnie</u>	25a. REC'D BY REGISTRAR <u>JAN 16 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>Annapolis</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>		d. STREET ADDRESS <b>179 West Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Ida</b> Middle <b>Louise</b> Last <b>BIAS</b>		4. DATE OF DEATH Month <b>January</b> Day <b>6</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 23, 1900</b>
9. AGE (In years last birthday) <b>66</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Annapolis, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Eugene Galloway</b>		14. MOTHER'S MAIDEN NAME <b>Frances Johnson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Walter Bias 179 West St.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolism</b> DUE TO <b>332X Decrease in Blood Circulation</b> DUE TO <b>Cerebral Infarction</b>		INTERVAL BETWEEN ONSET AND DEATH <b>8 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12-26-66</b> , 19__, to <b>1-6-67</b> , 19__, that (I) (we) last saw the deceased alive on <b>1-6-67</b> , 19__, and that death occurred at <b>3:30 A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>A. T. Allen</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>A T ALLEN</b>		22d. ADDRESS <b>62 Craddock St</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/10/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Burial Ground Annapolis</b>		23d. LOCATION (City or Town) (County) (State) <b>AA Ind</b>	
24. FUNERAL DIRECTOR <b>WM Russell Annapolis, Md</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>JAN 10 1967</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hr after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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00074  
MARYLAND STATE BOARD OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
00074

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Greenland Beach</b>		c. LENGTH OF STAY IN 1b <b>4 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>114 Greenland Beach Road</b>		d. STREET ADDRESS <b>114 Greenland Beach Rd.</b>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>ELIZABETH</b> Last <b>BLANKENSHIP</b>		4. DATE OF DEATH Month <b>January</b> Day <b>2</b> Year <b>19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 14, 1900</b>
9. AGE (In years lost birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months <b>66</b> Days <b>66</b> Hours <b>66</b> Min. <b>66</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Chaude Hunley</b>		14. MOTHER'S MAIDEN NAME <b>Lola B. Taylor</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>(If yes, give war or dates of service)</b>	
17. INFORMANT <b>Mrs. Virginia Reed</b>		Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>MALNUTRITION</b> DUE TO (c) <b>CEREBRAL ATHEROSCLEROSIS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>2 mos</b> <b>few yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Rheumatoid Arthritis = ankylosing spondylitis.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <b>(Signature)</b> , attended the deceased from <b>1963, to 1/2 1967</b> , that (I) <b>(Signature)</b> last saw the deceased alive on <b>1/2 1967</b> , and that death occurred at <b>7:35 P.M.</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>C. Earl Hill</b>		22b. DATE SIGNED <b>1/2/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>C. Earl Hill</b>		22d. ADDRESS <b>Riviera Beach, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan. 5, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Bluefield, West Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>George J. Gonce</b>		25a. REC'D BY REGISTRAR <b>JAN 9 1967</b>	
ADDRESS <b>4001 Ritchie Hwy Balto. Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal of the body. In any event within 72 hours after death.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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1 PLACE OF DEATH a COUNTY <u>AA CO</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>PA.</u> b COUNTY <u>Summit</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BROOKLYN - BALTIMORE 7 days</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOYNTON</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>179 Meadow Street</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Gertrude</u> Middle <u>Broadwater</u> Last <u>K</u>		4 DATE OF DEATH Month <u>1</u> Day <u>9</u> Year <u>1967</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>May 3, 1893</u>
9 AGE (In years last birthday) <u>73</u> yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Housewife</u>	
10b KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11 BIRTHPLACE (State or foreign country) <u>Summit Co., PA.</u>	
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13 FATHER'S NAME <u>William H. Buttner</u>	
14 MOTHER'S MAIDEN NAME <u>Ellen Shove</u>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16 SOCIAL SECURITY NO <u>?</u>		17 INFORMANT <u>Mrs Mary Schuck, Shillington, PA.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>arteriosclerosis fundus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Stroke</u> (c) <u>Interval between onset and death</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month Day Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. L. Hought</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. L. Hought</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <u>1-5-67</u>	
22. DATE SIGNED			
23a BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b DATE THEREOF <u>1-12-67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Shillington I.O.O.F.</u>	23d LOCATION (City or Town) (County) (State) <u>Shillington Summit PA.</u>
24. FUNERAL DIRECTOR <u>Arthur A. Hought</u>		25a REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>Shillington, PA.</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
		DATE <u>JAN 13 1967</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or reinterment and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00076

CERTIFICATE OF DEATH

00076

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>		d. STREET ADDRESS <b>7 Monument St.,</b>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Henry</b> Last <b>BROWN</b>		4. DATE OF DEATH Month <b>January</b> Day <b>5</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 25, 1898</b>
9. AGE (In years last birthday) <b>68</b> yrs		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>William H Brown Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Gene Jennings</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Edna Brown 7 Monument St.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Concave heart failure</b> <b>432.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>Heart</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Heart</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Multiple myeloma, hepatocarcinoma, leukemia</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) <b>Robert Biern</b> attended the deceased from <b>July</b> , 19 <b>66</b> , to <b>January 5</b> , 19 <b>67</b> , that (I) <b>Robert Biern</b> saw the deceased alive on <b>Jan. 5</b> , 19 <b>67</b> , and that death occurred at <b>9:30</b> M, from causes on and the date stated above.			
22a. SIGNATURE <b>Robert Biern</b>		22b. DATE SIGNED <b>1/6/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert Biern, M.D.</b>		22d. ADDRESS <b>121 Cathedral St., Annapolis, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>1-9-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Ann's</b>	23d. LOCATION (City or Town) (County) (State) <b>Annapolis, Md.</b>
24. FUNERAL DIRECTOR <b>William Reesett, Jr.</b>		25a. REC'D BY REGISTRAR <b>James Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>James Judge</b>		DATE <b>JAN 10 1967</b>	

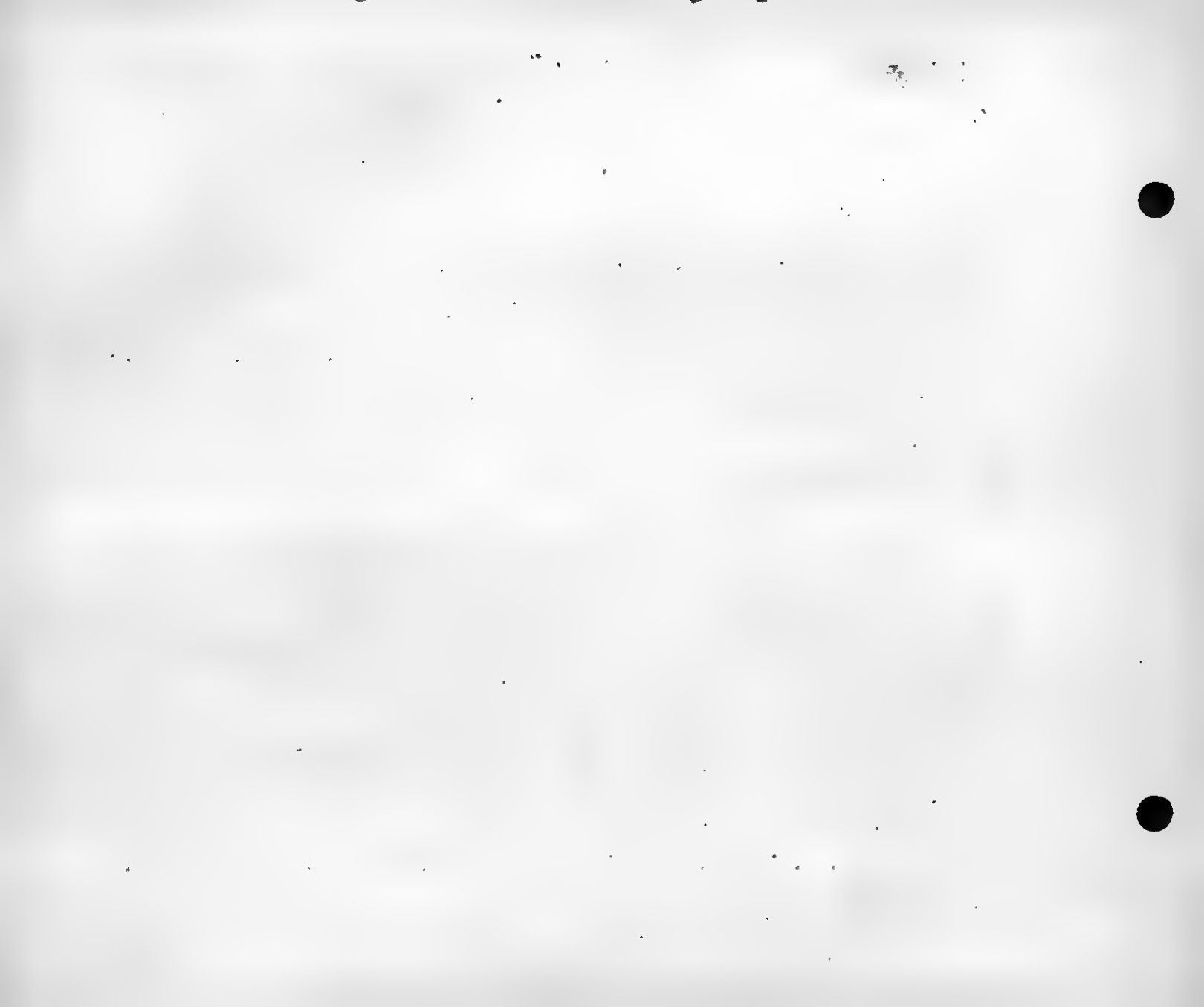


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
00077					CERTIFICATE OF DEATH					00077				
1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ANNAPOLIS					c. LENGTH OF STAY IN 1b 1 Hr.					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ANNAPOLIS				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) NAVAL HOSPITAL					d. STREET ADDRESS NAVAL HOSPITAL					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last JOSEPHINE ELIZABETH CALDWELL					4. DATE OF DEATH Month Day Year JANUARY 13 1967									
5. SEX Female		6. COLOR OR RACE CAUC		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 13 January 1967		9. AGE (In years last birthday) yrs. Months Days Hours Min. 1 5						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (County & State, or foreign country) Anne Arundel, Maryland				
12. CITIZEN OF WHAT COUNTRY? U.S.					13. FATHER'S NAME JAMES CALDWELL					14. MOTHER'S MAIDEN NAME MARGARET MARY ANDERSON				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO. (If yes give war or dates of service)					17. INFORMANT Hospital Records Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c)										INTERVAL BETWEEN ONSET AND DEATH 1 hour				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)														
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				
20f. (City or town) (County) (State)														
21. I certify that (I) (this hospital) attended the deceased from 13 JAN 1967 to 13 JAN 1967, that (I) (we) last saw the deceased alive on 13 JAN 1967, and that death occurred at 8:20 P.M. from the causes and on the date stated above.														
22a. SIGNATURE C. L. Gaudry, Jr. M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>														
22b. DATE SIGNED 13 JAN 1967														
22c. PHYSICIAN'S NAME (Type) C. L. GAUDRY, LT MC USN														
22d. ADDRESS NAVAL HOSPITAL, ANNAPOLIS, MD.														
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE THEREOF 11-16-67					23c. NAME OF CEMETERY OR CREMATORY U.S.N. ACADEMY				
23d. LOCATION (City, town, or county) (State) ANNAPOLIS MD.					23e. REC'D BY REGISTRAR JAN 18 1967					23f. REGISTRAR'S SIGNATURE Charles Judge				
24. FUNERAL DIRECTOR John M. Taylor Sons Annapolis, Md.														



00078

## CERTIFICATE OF DEATH

00079

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY IN 1b <u>///////</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>N. Arundel Hospital</u>		d. STREET ADDRESS <u>323 Hickory Point Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>CARMELO FRANK CATALDI, Sr.</u>		4. DATE OF DEATH Month <u>January</u> Day <u>14</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 8, 1921</u>
9. AGE (In years last birthday) <u>45</u> yrs		10. IF UNDER 24 HRS Months <u>1</u> Days <u>14</u> Hours <u>19</u> Min <u>67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Used Car Dealer (Ret.) Self Employed</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Anthony Cataldi</u>	
14. MOTHER'S MAIDEN NAME <u>Mary Busso</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>Jul 11</u>	
16. SOCIAL SECURITY NO <u>214-18-6359</u>		17. INFORMANT <u>Mrs. Eleanor Cataldi (wife) Same as #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY <u>105X</u> IMMEDIATE CAUSE (a) <u>Carcinoma of the left lung with metastases to the brain</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>metastases to the brain</u> (c) <u>1 year</u>		INTERVA. BETWEEN ONSET AND DEATH <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>none</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>2/15</u> , 19 <u>58</u> , to <u>1/12</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1/13</u> , 19 <u>67</u> , and that death occurred at <u>12</u> M, from causes and on the date stated above.	
22a. SIGNATURE <u>R.M. McLaughlin</u>		22b. DATE SIGNED <u>1/17/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>R.M. McLaughlin</u>		22d. ADDRESS <u>3308 Mountain Rd. Pasadena, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 19, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Mem. Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Glen Burnie, Maryland</u>	
24. FUNERAL DIRECTOR <u>Engel B. Fleming</u>		25a. REC'D BY REGISTRAR <u>Singleton Funeral Home</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JAN 19 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00079						00080					
1. PLACE OF DEATH a. COUNTY <u>St. R. Co.</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>St. R. Co.</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>						c. LENGTH OF STAY IN 1b <u>10 years</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>RR 2 Box 699 - St. Martin's Lane</u>						e. STREET ADDRESS <u>RR 2 Box 699</u>					
3. NAME OF DECEASED (Type or print) First <u>ELIZABETH</u> Middle <u>CHICK</u> Last <u>CHICK</u>						4. DATE OF DEATH Month <u>1</u> Day <u>1</u> Year <u>1967</u>					
5. SEX <u>FEM.</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-15-55</u>		9. AGE (in years last birthday) <u>12</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)			
13. FATHER'S NAME <u>KALINCSAK</u>				14. MOTHER'S MAIDEN NAME <u>?</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>				17. INFORMANT Address <u>MARGARET BENSINGER - ABOVE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Liposarcoma, left supra-clavicular area</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>—</u> DUE TO (c) <u>—</u>										INTERVAL BETWEEN ONSET AND DEATH <u>5 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Aug.</u> , 19 <u>57</u> , to <u>Jan.</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Dec.</u> , 19 <u>66</u> , and that death occurred at <u>9:30 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Francis I. Codd</u>						22b. DATE SIGNED <u>1-2-67</u>					
22c. PHYSICIAN'S NAME (Type) <u>Francis I. Codd M.D.</u>						22d. ADDRESS <u>Severna Park, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>1-4-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		23d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md</u>					
24. FUNERAL DIRECTOR <u>Charles S. Barrance, Severna Park, Md</u>						25a. REG'D BY REGISTRAR <u>—</u> 25b. REGISTRAR'S SIGNATURE <u>Judge</u>					
DATE <u>1</u> 1967											

REBIRIS. BARRANCE



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00080

## CERTIFICATE OF DEATH

00081

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>MARYLAND</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. LENGTH OF STAY IN lb <u>3 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>				d. STREET ADDRESS <u>607 Pennsylvania Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>#26249 George</u>				<b>4. DATE OF DEATH</b> Month <u>1</u> Day <u>5</u> Year <u>1967</u>		First Middle Last <u>Colbert</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/12/1912</u>	
9. AGE (in years at birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS Hours _____ Min. _____		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (County & State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Unk.</u>		16. SOCIAL SECURITY NO <u>Unk.</u>		17. INFORMANT <u>Hospital Records</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ DUE TO _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>Chronic Brain Syndrome due to Convulsive Disorder (Epilepsy)</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>-----</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>o.m.</u> _____ p.m. _____ 19 <u>67</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-----</u>		20f. (City or town) (County) (State) <u>-----</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>10/18/1963</u> , to <u>1/5/1967</u> , that (I) (we) last saw the deceased alive on <u>1/5/1967</u> , and that death occurred at <u>8:48 A.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/5/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. Benedict, M.D.</u>				22d. ADDRESS <u>Crownsville State Hospital, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>Jan 7/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt Calvary Cem</u>		23d. LOCATION (City or Town) (County) (State) <u>94 County Md</u>	
24. FUNERAL DIRECTOR <u>Special T. Clickorn</u>				ADDRESS <u>1129 N. Calver St</u>		25a. REC'D BY REGISTRAR <u>DATE JAN 9 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				25c. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

11



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File in office and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00082

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00082

1 PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Res. before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>North Arundel General Hospital</b>			d. STREET ADDRESS <b>1529 Ingalls Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3 NAME OF DECEASED (Type or print) <b>WILLIAM ATWELL CRAWFORD</b>			4 DATE OF DEATH Month <b>1</b> Day <b>10</b> Year <b>19 67</b>		
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>10/6/27</b>	9 AGE (In years last birthday) <b>39 yrs</b>	IF UNDER 1 YEAR Months <b>10</b> Days <b>19</b> Hours <b>67</b> Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TRUCK DRIVER</b>		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13 FATHER'S NAME <b>JOSEPH P. CRAWFORD, SR.</b>			12 CITIZEN OF WHAT COUNTRY? <b>USA</b>		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES</b>			16 SOCIAL SECURITY NO		
17 INFORMANT <b>MARY E. CRAWFORD GLEN BURNIE, MD.</b>			Address		
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac Tamponade</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Laceration of Aorta</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 8) <b>Passenger in auto-fixed object accident</b>			
20c. TIME OF INJURY Month, Day, Year <b>8:30 AM 1 10 19 67</b>		20d. INJURY OCCURRED Where <input type="checkbox"/> Not Where <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street</b>	
20f. (City or town) <b>Anne Arundel</b>		20g. (County) <b>Md.</b>		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from <b>Natural causes</b> <input type="checkbox"/> <b>Accident</b> <input checked="" type="checkbox"/> <b>Suicide</b> <input type="checkbox"/> <b>Homicide</b> <input type="checkbox"/> <b>Undetermined manner</b> <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Rudiger Breiteneker, M.D.</b>		22. DATE SIGNED <b>1/11/67</b>		22. DATE SIGNED	
EXAMINER'S NAME (Type)		Address (Street, city, town, or county)			
23a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>1/16/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL CEM.</b>	
23d. LOCATION (City or Town) <b>ARLINGTON, VIRGINIA</b>		23e. (County)		23f. (State)	
24 FUNERAL DIRECTOR <b>HOWARD H. HUBBARD 4107 WILKENS AVE. 21229</b>			25a. REC'D BY REGISTRAR DATE <b>13 1967</b>		
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal of the body. Retain any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00082

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00083

1 PLACE OF DEATH a COUNTY <b>Anne Arundel</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if not last residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>		c LENGTH OF STAY & 1b <b>Millersville</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>North Arundel Hospital</b>		d STREET ADDRESS <b>Rt. 2, Box 300</b>	
3 NAME OF DECEASED (Type or print) <b>KERMIT E. CREWS</b>		4 DATE OF DEATH Month <b>January</b> Day <b>14</b> Year <b>19 67</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH <b>Feb. 17, 1910</b>
9a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Service Station Mechanic</b>		9b KIND OF BUSINESS OR INDUSTRY <b>Winston-Salem, N. C.</b>	9c AGE (In years last birthday) <b>56</b> yrs
10a USUAL RESIDENCE (If not in hospital give street address) <b>North Arundel Hospital</b>		11 BIRTHPLACE (State or foreign country) <b>Winston-Salem, N. C.</b>	12 CITIZENSHIP OF WHAT COUNTRY? <b>U.S.</b>
13 FATHER'S NAME <b>Oscar E. Crews</b>		14 MOTHER'S MAIDEN NAME <b>Mary Phipps</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)		16 SOCIAL SECURITY NO <b>None</b>	
17 INFORMANT <b>Frank Voglar Funeral Home</b>		Address <b>Winston-Salem North Carolina</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY <b>812.4 IMMEDIATE CAUSE (a) Multiple Extreme Injuries.</b> DUE TO (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) <b>Pedestrian struck by motor vehicle</b>	
20c TIME OF DEATH Hour <b>6:00</b> p.m. Month <b>1/</b> Day <b>14</b> Year <b>1967</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <b>Street</b>
20f (City or town) <b>Millersville</b>		(County) <b>A.A.</b> (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles S. Petty</b>		M.D.	
EXAMINER'S NAME (Type) <b>Charles S. Petty</b>		22. DATE SIGNED <b>1/15/67</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b DATE THEREOF <b>1/16/1967</b>	
23c NAME OF CEMETERY OR CREMATORY <b>Bunker Hill Cemetery</b>		23d LOCATION (City or town) (County) (State) <b>Forsyth County, N. C.</b>	
24. FUNERAL DIRECTOR <b>Wm. J. Tibbitts &amp; Sons</b>		25a REC'D BY REGISTRAR <b>Baltimore, Md.</b>	
25b REGISTRAR'S SIGNATURE <b>Wm. J. Tibbitts &amp; Sons</b>		DATE <b>JAN 17 1967</b>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00083

## CERTIFICATE OF DEATH

00084

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN 1b <b>2 mos. 2 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Crownsville State Hospital</b>		e. STREET ADDRESS <b>923 Dantry Ct.</b>	
3 NAME OF DECEASED (Type or print) <b>3-#33947 Anna Marie Cummings</b>		4 DATE OF DEATH Month <b>1</b> Day <b>29</b> Year <b>19 67</b>	
5 SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 28, 1925</b>
9. AGE (In years last birthday) <b>41</b> yrs.		10. IF UNDER 1 Year Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waitress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>Johnstown, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Cummings</b>		14. MOTHER'S MAIDEN NAME <b>Katherine Smith</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>198-20-4243</b>	
17 INFORMANT <b>Hospital Records</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure</b> DUE TO (b) <b>Bronchopneumonia</b> DUE TO (c) <b>Arteriosclerotic Cardiovascular Disease</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-----</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. --- p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-----</b>	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>11/27</b> , 19 <b>66</b> to <b>1/29</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>1/29</b> , 19 <b>67</b> , and that death occurred at <b>11:30 A.M.</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>[Signature]</i>		22b. DATE SIGNED <b>1/30/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. Benedict, M. D.</b>		22d. ADDRESS <b>Crownsville State Hospital, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>2-1-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Memorial Pk.</b>	23d. LOCATION (City or Town) (County) (State) <b>Ritchie Hgwy., A.A.Co., Md.</b>
24. FUNERAL DIRECTOR <b>George J. Gonce-4001 Ritchie Hgwy., Baltimore</b>		25a. REC'D BY REGISTRAR <b>DATE FEB 2 1967</b>	25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>

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00084

## CERTIFICATE OF DEATH

00085

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>1 mo. 7 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - Annapolis</b>	
f. STREET ADDRESS <b>6 Riverdale Dr. Winchester on</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Peter DARAGO</b>		4. DATE OF DEATH Month <b>January</b> Day <b>3</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 29, 1885</b>
9. AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR Months <b>2</b> Days <b>27</b> Hours <b>15</b> Min <b>00</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Coal Miner</b>		12. KIND OF BUSINESS OR INDUSTRY <b>Mining</b>	
13. BIRTHPLACE (County & State, or foreign country) <b>Hungary</b>		14. CITIZEN OF WHAT COUNTRY <b>USA</b>	
15. FATHER'S NAME <b>John Darago</b>		16. MOTHER'S M A DEN NAME <b>Elizabeth Szabo</b>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		18. SOCIAL SECURITY NO. <b>-</b>	
19. INFORMANT <b>Theresa Darago</b>		Address <b>#2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pulmonary embolism</b> <b>400X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Regional Enteritis w. hemorrhage, Severe w. uremia, Jaundice's carbons</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the doctor) attended the deceased from <b>11/26</b> , 19 <b>66</b> , to <b>Jan. 3</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>Jan. 3</b> , 19 <b>67</b> , and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE <b>Richard N. Peeler</b>		22b. DATE SIGNED <b>1/4/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Richard N. Peeler, M.D.</b>		22d. ADDRESS <b>121 Cathedral St., Annapolis, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-6-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Steubenville Ohio</b>	
24. FUNERAL DIRECTOR <b>John M. Taylor &amp; Sons</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>JAN 5 1967</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

00085

MARYLAND STATE DEPARTMENT OF HEALTH

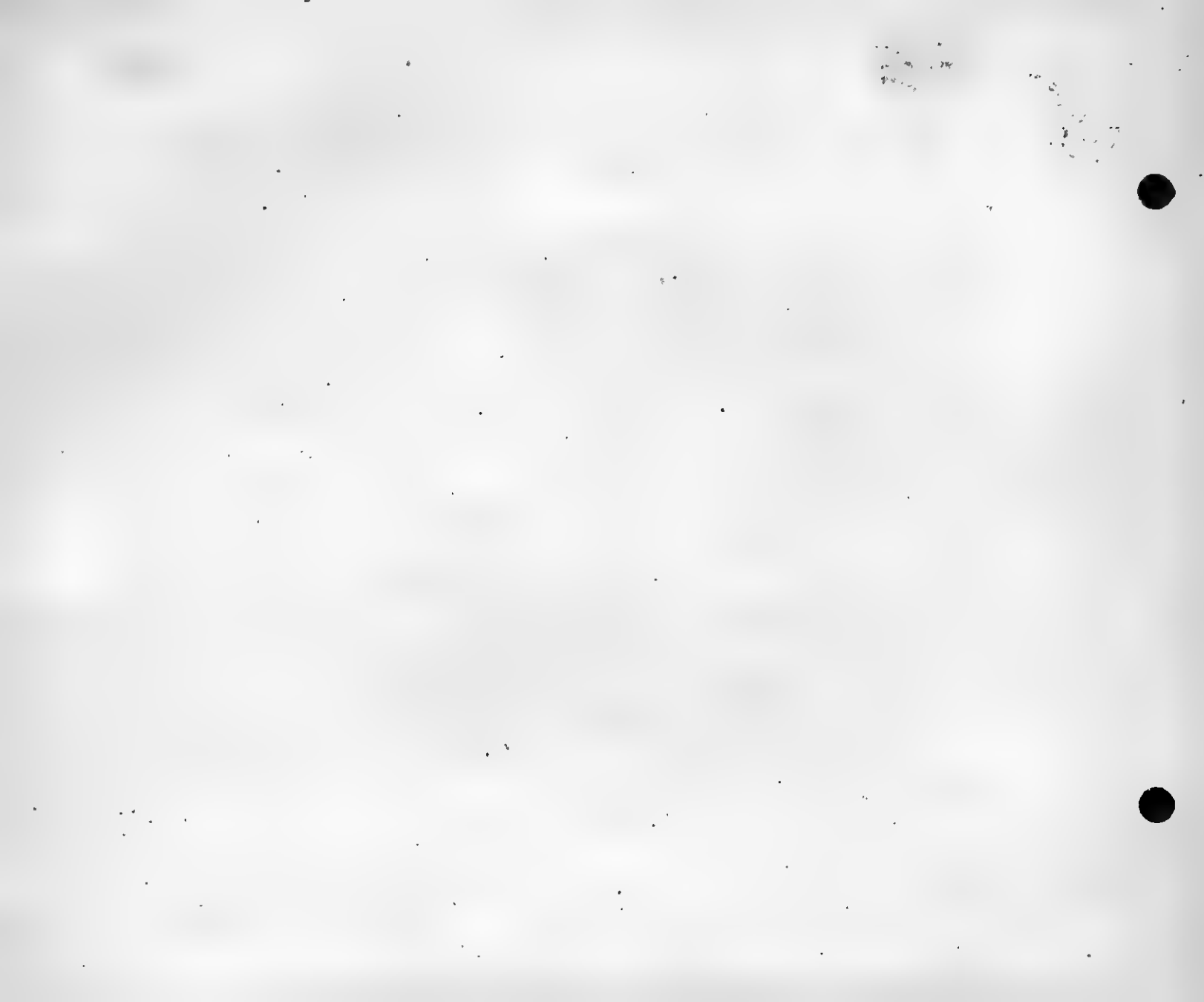
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00086

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park Md</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park Md</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>214 Oak Ave</u>				d. STREET ADDRESS <u>214 Oak Ave</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Robert Maurice Davis</u>				4. DATE OF DEATH Month Day Year <u>1-25-67</u> 19			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 3, 1895</u>	9. AGE (in years last birthday) <u>71</u> yrs.	IF FUNER 1 YEAR Months Days	IF FUNER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Banker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bank</u>		11. BIRTH PLACE (County & State, or foreign country) <u>Severna Park Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>David S Davis</u>				14. MOTHER'S MAIDEN NAME <u>Jill Davis</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>W.W.T 215 015 013</u>		17. INFORMANT <u>Elmer Davis</u>		Address <u>Alone</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial inf</u> <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>a.c. inf</u> DUE TO (c) <u>Sen card</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1958</u> , 19 to <u>1967</u> , 19 that (I) (we) last saw the deceased alive on <u>Dec 1966</u> , and that death occurred at <u>5:45</u> PM, from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert R. Hahn</u> M.D.				22b. DATE SIGNED <u>1-25-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Robert R. HAHN</u>				22d. ADDRESS <u>80 Box 73 Severna Park</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>1-30-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Washington Nat'l Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Washington Va.</u>	
24. FUNERAL DIRECTOR <u>Robert S. Benanco, Severna Park, Md</u>				25a. REC'D BY REGISTRAR <u>1-31-67</u>			
25b. REGISTRAR'S SIGNATURE <u>Robert S. Benanco</u>				25c. DATE <u>JAN 31 1967</u>			

ATTEST: S. E. KIRKMAN



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and, in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00086

CERTIFICATE OF DEATH

00087

1 PLACE OF DEATH a COUNTY <u>A.A. Co.</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Res dence before admission) a STATE <u>M.D.</u> b COUNTY <u>A.A.</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c LENGTH OF STAY IN 1b	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>157 Prince George St.</u>		d STREET ADDRESS <u>157 Prince George St.</u>	
3 NAME OF DECEASED (Type or print) <u>MABEL M. DAVIS</u>		4 DATE OF DEATH Month <u>1</u> Day <u>18</u> Year <u>1967</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>2-20-1888</u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME</u>		10b KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>	11 BIRTHPLACE (County & State, or foreign country) <u>CORONADO, CAL.</u>
13 FATHER'S NAME <u>JOHN D. MATHEWSON</u>		14 MOTHER'S MAIDEN NAME <u>MARY NEVILLE</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16 SOCIAL SECURITY NO. <u>-</u>	
17 INFORMANT <u>MRS. R. H. MOORE JR. R.A. #2</u>		Address <u>AMBERLEY, MD.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Hemorrhage, cerebral</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>unfamiliar</u>			INTERVAL BETWEEN ONSET AND DEATH <u>unfamiliar</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1-18-</u> , 19 <u>67</u> , to <u>1-19-</u> , 19 <u>67</u> , that (I) <u>was</u> last saw the deceased alive <u>on</u> <u>1-19-</u> , 19 <u>67</u> , and that death occurred at <u>4:30</u> P.M. from causes and on the date stated above.			
22a SIGNATURE <u>W. P. STEPHENS</u>		22b DATE SIGNED <u>1-19-67</u>	
22c PHYSICIAN'S NAME (Type) <u>W. P. STEPHENS</u>		22d ADDRESS <u>CORN HILL ST. ANNAPOLIS, MD</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b DATE THEREOF <u>1-20-67</u>	23c NAME OF CEMETERY OR CREMATORY <u>U.S. NAVAL ACADEMY</u>	23d LOCATION (City or Town) (County) (State) <u>ANNAPOLIS A.A. MD.</u>
24 FUNERAL DIRECTOR <u>John M. Layton &amp; Sons</u>		25a REC'D BY REGISTRAR DATE <u>JAN 21 1967</u>	
ADDRESS <u>Annapolis, Md</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1977



## CERTIFICATE OF DEATH

00088

1 PLACE OF DEATH a. COUNTY <u>A. Co</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u> c. LENGTH OF STAY IN 1b <u>6 months</u>		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>A. Co</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>131 Round Bay Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARIE DEAN DILLES</u>		4 DATE OF DEATH <u>1-15-67</u>	
5 SEX <u>FEMALE</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>11-7-82</u>
9 AGE (In years last birthday) <u>84</u> yrs.		10 IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>1</u> Days <u>15</u> Hours <u>15</u> Min <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>@ home</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Belgium</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13 FATHER'S NAME <u>Unknown</u>		14 MOTHER'S MARRIED NAME <u>Unknown</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Hugo Coelius</u>		Address <u>Above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>1 day</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at <u>10:00</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Ray M. Smith</u>		22b. DATE SIGNED <u>1-15-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>RAY M. SMITH M.D.</u>		22d. ADDRESS <u>SEVERNA PARK Md.</u>	
23a. BURIAL, CREMATION, RESURRA (Specify)	23b. DATE THEREOF <u>1-18-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Annapolis A.A. Co.</u>
24 FUNERAL DIRECTOR <u>Robert S. Barranco</u>		25a. REC'D BY REGISTRAR <u>Severna Ph. Ind</u>	
25b. REGISTRAR'S SIGNATURE <u>James Judge</u>		DATE <u>JAN 18 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE  
HEALTH DEPT.

00088

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00089

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>P.A.C.O</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>MD</u> b COUNTY <u>ANNE ARUNDEL</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Plen Buerie</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mulberry Road - Hanover</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. - NORTH ARUNDEL</u>		d STREET ADDRESS <u>7412 - Mulberry Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>Blanche</u> Middle <u>9</u> Last <u>DREIER</u>		4 DATE OF DEATH Month <u>1</u> Day <u>21</u> Year <u>1967</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>12-15-95 1894</u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home Maker</u>		10b KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	9 AGE (In years last birthday) <u>72</u> yrs
11 BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>William Stable</u>		14 MOTHER'S MAIDEN NAME <u>Jannie Green</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>NONE</u>	
17 INFORMANT <u>William Dreier - Same with</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY <u>450.0</u> IMMEDIATE CAUSE (a) <u>arteriosclerosis generalized</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>hours</u>
PART 1. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>[Signature]</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. Linbar</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <u>1-21-67</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>1/24/67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Landon Park Cemetery Balto.</u>	23d LOCATION (City or Town) (County) (State) <u>Md</u>
24 FUNERAL DIRECTOR <u>Robert Pugh</u>		25a REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>Singleton Funeral Home / Plen Buerie</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

00089

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00090

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1 PLACE OF DEATH a. COUNTY <b>AA CO</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institut on Residence before admission) a. STATE <b>MASS</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gen Burnie</b>		c. LENGTH OF STAY IN 1b <b>Framingham - Center</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>North-ARUNDEL - Hospital</b>		e. STREET ADDRESS <b>87 State Street</b>	
3. NAME OF DECEASED (Type or print) <b>Elizabeth VAN PRAAG Dudley</b>		4. DATE OF DEATH Month <b>1</b> Day <b>19</b> Year <b>1967</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>4-10-98</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Bookkeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>68</b> yrs
11. BIRTHPLACE (State or foreign country) <b>New York City, New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Porter Van Praag</b>		14. MOTHER'S MAIDEN NAME <b>Grace Coolidge</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>019-10-5421</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>445X</b> IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cerebrovascular Disease</b> (c)			INTERVAL BETWEEN ONSET AND DEATH <b>3 hours.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>E. Linhardt</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>E. Linhardt</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <b>1-19-67</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Jan. 22, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Edgell Grove</b>	23d. LOCATION (City or Town) (County) (State) <b>Framingham, Mass.</b>
24. FUNERAL DIRECTOR <b>William J. Rickman &amp; Sons North Pa. Ave.</b>		25a. REC'D BY REG STRAR <b>DATE JAN 20 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>James Judge</b>	



00090

## CERTIFICATE OF DEATH

00091

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived or institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>1413 West Street</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Sherod Leaphart EARLE</b>		4. DATE OF DEATH Month Day Year <b>January 31 19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 13, 1900</b>
9. AGE (In years last birthday) <b>66 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ENGINEER</b>		12. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't</b>	
13. BIRTHPLACE (County & State, or foreign country) <b>Jacksonville Florida</b>		14. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
15. FATHER'S NAME <b>SHEROD L. EARLE</b>		16. MOTHER'S MAIDEN NAME <b>MARY COULTER</b>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		18. SOCIAL SECURITY NO <b>Ruth EARLE #2</b>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> 4.01 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>HYPERTENSIVE HEART DISEASE</b> DUE TO (c) <b>10 YRS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 HOURS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>June 1960</b> to <b>1/31 1967</b> , that (I) (we) last saw the deceased alive on <b>1/31 1967</b> , and that death occurred at <b>7:10 P.M.</b> from causes and on the date stated above			
22a. SIGNATURE <b>George J. Bees</b>		22b. DATE SIGNED <b>2-1-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Franklin St. Annapolis, Md.</b>		22d. ADDRESS <b>FRANKLIN ST. ANNAPOLIS, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>2-3-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>	23d. LOCATION (City or Town) (County) (State) <b>RADENSBURG MD.</b>
24. FUNERAL DIRECTOR <b>John M. Lazarus Annapolis, Md.</b>		25. REG'D BY REGISTRAR <b>Feb 6 1967</b>	
26. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00094					00092				
1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>			c. LENGTH OF STAY IN 1b <u>4 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GALESVILLE</u>			d. STREET ADDRESS <u>BOX 33</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>NAVAL HOSPITAL</u>					e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>HARLEY</u> Middle <u>ALLEN</u> Last <u>EDWARDS</u>		4. DATE OF DEATH Month <u>JANUARY</u> Day <u>19</u> Year <u>1967</u>		5. SEX <u>MALE</u>		6. COLOR OR RACE <u>CAUC</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>1 JULY 1900</u>		9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		11. BIRTHPLACE (County & State, or foreign country) <u>E. SPENCER N. CAROLINA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U. S. ARMY OFFICER</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>USA RETIRED</u>				
13. FATHER'S NAME <u>JOHN FRANKLIN EDWARDS</u>					14. MOTHER'S MAIDEN NAME <u>MARY BRACKON</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES</u> <u>32 years</u>					16. SOCIAL SECURITY NO. <u>213-34-3104</u>				
17. INFORMANT <u>WIFE</u>					Address <u>BOX 33</u> <u>MABEL C. EDWARDS</u> <u>GALESVILLE, MARYLAND</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Branchogenic Carcinoma</u> 162-1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>16 JAN</u> , 19 <u>67</u> , to <u>19 JAN</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>19 JAN 67</u> 19 <u>67</u> , and that death occurred at <u>1125A</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>William P. Ahentzen</u> M.D.								22b. DATE SIGNED <u>19 JAN 67</u>	
22c. PHYSICIAN'S NAME (Type) <u>W. P. AHENTZEN, CAPT MC HSN</u>								22d. ADDRESS <u>USNH ANNAPOLIS, MARYLAND</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan 23, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL</u>		23d. LOCATION (City, town or county) (State) <u>ARLINGTON, VA.</u>			
24. FUNERAL DIRECTOR <u>Hardesty Funeral Home, Galesville, Md</u>				25a. REC'D BY REGISTRAR <u>  </u>		25b. REGISTRAR'S SIGNATURE <u>James Judge</u>			
DATE <u>JAN 23 1967</u>									

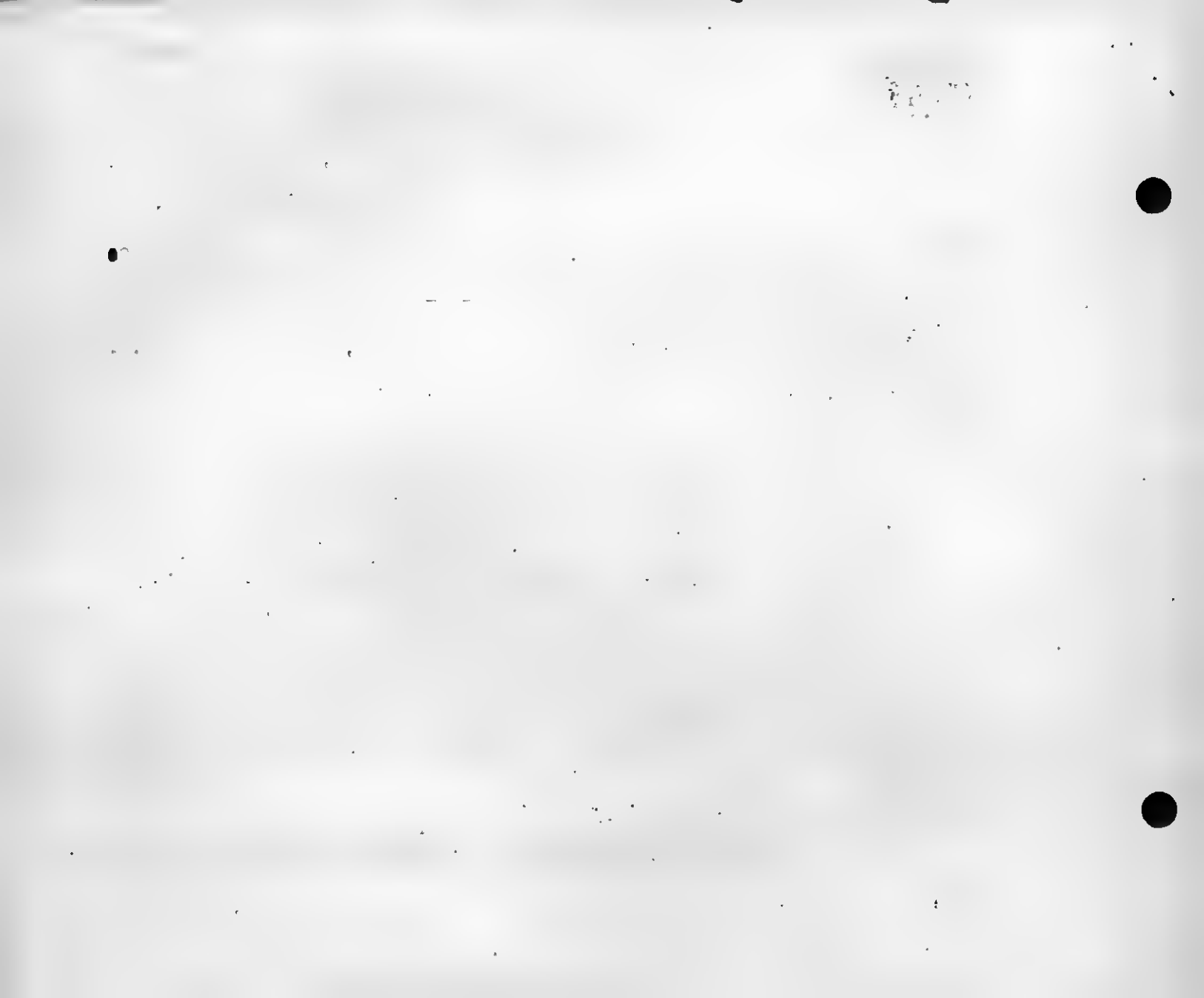
22



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00092					00093				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY Anne Arundel					a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie					b. COUNTY Anne Arundel				
c. LENGTH OF STAY IN 1b 12 days					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie,				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) North Arundel Hospital					d. STREET ADDRESS 116 XXXXX Carroll Rd.				
3. NAME OF DECEASED (Type or print) Mabel					4. DATE OF DEATH 1 20 1967				
5. SEX Female					6. COLOR OR RACE White				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH 5-11-91				
9. AGE (In years last birthday) 75 11 yrs.					10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.				
11. BIRTHPLACE (County & State, or foreign country) Anne Arundel, Maryland					12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME George E. Britton					14. MOTHER'S MAIDEN NAME Elizabeth Coleburn				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO					16. SOCIAL SECURITY NO. 216-14-7088				
17. INFORMANT Roy Ellis - Same as # 2					Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis. DUE TO (b) Carcinoma of pancreas. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Generalized arteriosclerosis. DUE TO (c) Partial small bowel obstruction with uremia.									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19									
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from Oct. 16, 1967, to Jan. 20, 1967, that (I) (we) last saw the deceased alive on Jan. 20, 1967, and that death occurred at 9:40 AM, from the causes and on the date stated above.									
22a. SIGNATURE Edmond I. Marshak									
22b. DATE SIGNED									
22c. PHYSICIAN'S NAME (Type) Edmond I. Marshak									
22d. ADDRESS Ritchie Highway, Glen Burnie, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial									
23b. DATE THEREOF 1/25/67									
23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery									
23d. LOCATION (City, town or county) (State) Woodlawn, Maryland									
24. FUNERAL DIRECTOR R. Rube									
25a. REC'D BY REGISTRAR DATE JAN 24 1967									
25b. REGISTRAR'S SIGNATURE Charles Judge									



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

00093

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00094

1 PLACE OF DEATH a. COUNTY <u>ARMCO</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>ARMCO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harwood</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harwood</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anne Arundel General</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Sophie</u> Middle <u>N</u> Last <u>Francis</u>		4 DATE OF DEATH Month <u>1</u> Day <u>9</u> Year <u>1967</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>1977</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		9b. AGE (In years last birthday) <u>90</u>	
10a. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11 BIRTHPLACE (State or foreign country) <u>West River, Md.</u>	
12 CITIZEN OF WHAT COUNTRY? <u>USA</u>		13 FATHER'S NAME <u>Edgar Shepherd</u>	
14 MOTHER'S MAIDEN NAME <u>Agnes McConey</u>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16 SOCIAL SECURITY NO. <u>—</u>		17 INFORMANT <u>Sophie N. Chanoy</u> Address <u>Harwood, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO <u>Central embolism</u> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Central embolism</u> (c) <u>Central embolism</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12-22-66</u> <u>10</u> <u>1-9-67</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Stroke at home</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>2</u> p.m. <u>12-22-1966</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Harwood ARMCO MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhardt</u> M.D.		22. DATE SIGNED <u>1-9-67</u>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county)		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1-11-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Christ Church</u>	23d. LOCATION (City or Town) (County) (State) <u>Owensville ARM MD</u>
24. FUNERAL DIRECTOR <u>Bernard Hardesty</u>		25a. REC'D BY REGISTRAR DATE <u>20 1967</u>	
ADDRESS <u>Triloville ME</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

00095

00094

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>67 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>None</u>				d. STREET ADDRESS <u>PO Box 53</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Daisy</u> Middle <u>Therese</u> Last <u>Therese</u>				4. DATE OF DEATH Month <u>1</u> Day <u>19</u> Year <u>1967</u>			
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>Bl</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-26-09</u>		9. AGE (In years last birthday) <u>63</u> yrs.	10. IF UNDER 1 YEAR: Months <u>1</u> Days <u>19</u> Hours <u>16</u> Min <u>7</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private Home</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Val. Jones</u>				14. MOTHER'S MAIDEN NAME <u>Carl Therese Harwood, Md.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>none</u>		17. INFORMANT <u>Carl Therese Harwood, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> 1145A DUE TO <u>Hypertensive Cardio Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>None</u> (c) <u>None</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. <u>19</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>5-10-66</u> 19 <u>66</u> to <u>1-19-67</u> 19 <u>67</u> , that I last saw the deceased alive on <u>12-19-66</u> 19 <u>66</u> , and that death occurred at <u>1:40</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Carl T. Allen</u> M.D.				DATE SIGNED <u>1-19-67</u>			
PHYSICIAN'S NAME (Type) <u>ARIS T. ALLEN</u>							
22a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 23, 1967</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Churchton Cemetery</u>		22d. LOCATION (City, town, or county) <u>Churchton</u> (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John B. Johnson</u>				24a. REC'D BY REGISTRAR <u>Charles Judge</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
ADDRESS <u>Ann Md</u>				DATE <u>JAN 23 1967</u>			



# MARYLAND STATE DEPARTMENT OF HEALTH

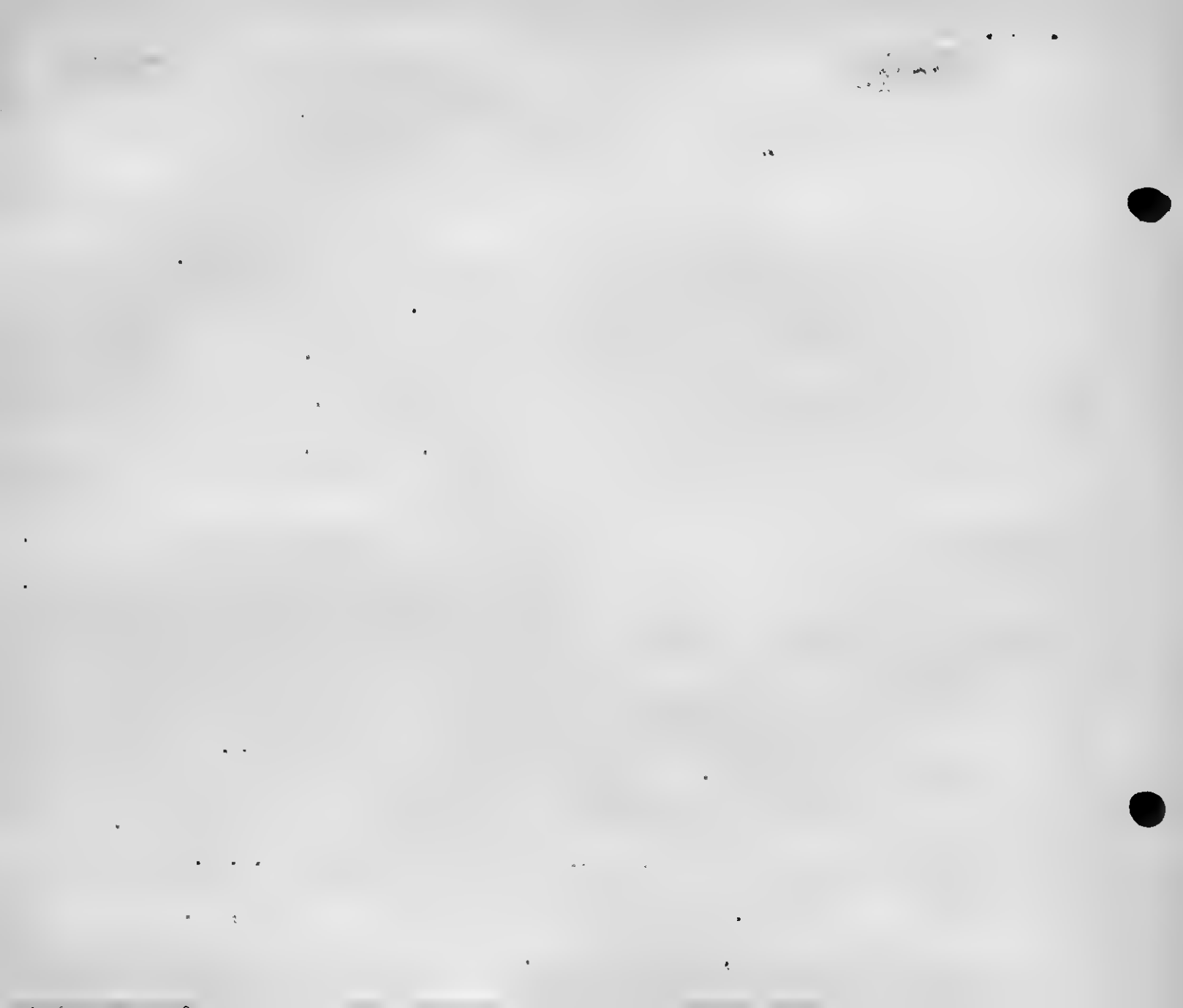
## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

00095

00096

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> <span style="float: right;">DOA</span> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>North Arundel Hospital</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>AA</u></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severn</u> d. STREET ADDRESS <u>Evergreen Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Charles Henry Fox</u>		<b>4. DATE OF DEATH</b> Month <u>Jan.</u> Day <u>7</u> Year <u>1967</u>			
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>			
<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>19 Dec, 1904</u>			
<b>9. AGE</b> (In years last birthday) <u>62</u> yrs.		<b>10. AGE</b> (In years last birthday) IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS.: Hours <u>  </u> Min. <u>  </u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Tronworker</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Shipyard</u>			
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Milton, Pa.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>			
<b>13. FATHER'S NAME</b> <u>Charles E. Fox</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Clara B.</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>162-05-0832</u>			
<b>17. INFORMANT</b> <u>Mrs. Jennie D. Fox, same as 2</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> DUE TO (b) <u>Angina Pectoris</u> DUE TO (c) <u>Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>Sudden</u> <u>2 yrs.</u> <u>5 yrs.</u>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>No injury</u>			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>		<b>20f. (City or town)</b> (County) (State) <u>  </u>			
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>16 August, 1965</u> to <u>7 Jan., 1967</u> , that (I) (we) last saw the deceased alive on <u>6 Jan., 1967</u> , and that death occurred at <u>10 PM</u> , from the causes and on the date stated above.					
<b>22a. SIGNATURE</b> <u>H. F. Manuzak</u>		<b>22b. DATE SIGNED</b> <u>9 Jan. 1967</u>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Hubert F. Manuzak, M. D.</u>		<b>22d. ADDRESS</b> <u>425 Ritchie Hwy, S. E., Glen Burnie</u>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>10 Jan. 1967</u>			
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Harmony Church Yard</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Milton, Pa.</u>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Kirkley Funeral Home, Glen Burnie, Md.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>J. M. J. J.</u>			
<b>25b. REGISTRAR'S SIGNATURE</b> <u>J. M. J. J.</u>		<b>DATE</b> <u>JAN 10 1967</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



00096

## CERTIFICATE OF DEATH

00097

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>North Arundel Hospital</b>		d. STREET ADDRESS <b>606 Jersey Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>James W. Gaylor</b>		4. DATE OF DEATH Month Day Year <b>1-11 19 67</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-31-1987</b>	
9. AGE (In years last birthday) <b>79</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter (Ret.)</b>		12. KIND OF BUSINESS OR INDUSTRY <b>Md. Dry Dock</b>	
13. BIRTHPLACE (County & State, or foreign country) <b>Penna. (Weatherly)</b>		14. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. FATHER'S NAME <b>Daniel Gaylor</b>		16. MOTHER'S MAIDEN NAME <b>Jennie Strutters</b>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No none</b>		18. SOCIAL SECURITY NO <b>185-09-4307</b>	
19. INFORMANT <b>Mrs. Pearl S. Gaylor (wife)</b>		Address <b>Same as #2</b>	
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Metastatic prostatic carcinoma</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <b>4 RS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
22a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		22b. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
22c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		22d. (City or town) (County) (State)	
23. I certify that (I) (this hospital) attended the deceased from <b>1-8</b> , 19 <b>67</b> , to <b>1-11</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>1-10</b> , 19 <b>66</b> , and that death occurred at <b>4:10</b> M, from causes and on the date stated above.			
24a. SIGNATURE <b>Ernest A. Leipold</b>		24b. DATE SIGNED <b>1-11-67</b>	
24c. PHYSICIAN'S NAME (Type) <b>Ernest A. Leipold M.D.</b>		24d. ADDRESS <b>Glen Burnie, Maryland</b>	
25a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		25b. DATE THEREOF <b>Jan. 14, 1967</b>	
25c. NAME OF CEMETERY OR CREMATORY <b>Freeland Cemetery</b>		25d. LOCATION (City or Town) (County) (State) <b>Luzerne, Co. Penna.</b>	
26. FUNERAL DIRECTOR <b>Richard V. Singleton</b>		26a. ADDRESS <b>Glen Burnie, Md.</b>	
26b. REC'D BY REGISTRAR <b>JAN 13 1967</b>		26c. REGISTRAR'S SIGNATURE <b>James Judge</b>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00097

00098

1 PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 15 <b>1 day</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgewater</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>		d. STREET ADDRESS <b>3525 South River Terrace</b>	
3 NAME OF DECEASED (Type or print) First <b>Merrill</b> Middle <b>Alexander</b> Last <b>GERHAB</b>		4 DATE OF DEATH Month <b>January</b> Day <b>12</b> Year <b>1967</b>	
5 SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>June 10, 1891</b>
9 AGE (In years last birthday) <b>75</b> yrs		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ref. Auto Parts</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Phila. Pennsylvania</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13 FATHER'S NAME <b>John R. Gerhab</b>		14. MOTHER'S MARDEN NAME <b>Cressman</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes WWI</b>		16. SOCIAL SECURITY NO. <b>1-11-111111</b>	
17. INFORMANT <b>Babette Gerhab</b>		Address <b>#2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> <b>531A</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (the hospital) attended the deceased from <b>DEC. 26, 1966</b> , to <b>Jan. 12, 1967</b> , that (I) (we) last saw the deceased alive on <b>Jan. 12, 1967</b> , and that death occurred at <b>M</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Richard I. Hochman, M.D.</b>		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED <b>1/13/67</b>
22c. PHYSICIAN'S NAME (Type) <b>Richard I. Hochman, M.D.</b>		22d. ADDRESS <b>59 Franklin St., Annapolis, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>1-14-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Hillside</b>	23d. LOCATION (City or Town) (County) (State) <b>Phila. Pa.</b>
24 FUNERAL DIRECTOR <b>John M. Taylor &amp; Sons Annapolis, Md.</b>		25a. REC'D BY REGISTRAR <b>Jan 16 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

VR AIS (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
00098 00099													
1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>NAVAL HOSPITAL</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u> d. STREET ADDRESS <u>812 PARKWOOD AVENUE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>LAURA</u> Middle <u>ARLENE</u> Last <u>GERRIOR</u>			4. DATE OF DEATH Month <u>JANUARY</u> Day <u>6</u> Year <u>19 67</u>			5. SEX <u>F</u>			6. COLOR OR RACE <u>W</u>				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>2-27-1895</u>			9. AGE (In years last birthday) <u>71</u> yrs.			10. UNDER 1 YEAR <input type="checkbox"/> UNDER 24 HRS. <input type="checkbox"/>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>			11. BIRTHPLACE (County & State, or foreign country) <u>LYNN, Mass.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>JUDSON CONDON</u>						14. MOTHER'S MARDEN NAME <u>ALICE HAYNES</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>-</u>			17. INFORMANT <u>VINCENT F. GERRIOR #2</u>			Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> 199.2 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)				
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>23 October</u> , 19 <u>66</u> to <u>6 January</u> , 19 <u>67</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>6 January</u> , 19 <u>67</u> , and that death occurred at <u>9:50</u> M, from the causes and on the date stated above.													
22a. SIGNATURE <u>Ward G. Gytson</u>						22b. DATE SIGNED <u>1/7/67</u>			22c. PHYSICIAN'S NAME (Type) <u>LCDR WARD G. GYTSON, MC USN</u>				
22d. ADDRESS <u>NAVAL HOSPITAL, ANNAPOLIS, MD.</u>						22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22f. M.D. <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF <u>1-16-67</u>			23c. NAME OF CEMETERY OR CREMATORY <u>U.S. NAVAL ACADEMY</u>			23d. LOCATION (City, town or county) (State) <u>ANNAPOLIS MD.</u>				
24. FUNERAL DIRECTOR <u>John M. Gytson</u>						25a. REC'D BY REGISTRAR <u>10</u>			25b. REGISTRAR'S SIGNATURE <u>10</u>				
DATE <u>JAN 10 1967</u>						DATE			DATE				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00059

CERTIFICATE OF DEATH

00100

1 PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>Annopolis</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>		d. STREET ADDRESS <b>316 West Street</b>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>Harvey Oliva GILMORE</b>		4 DATE OF DEATH Month Day Year <b>January 8 1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 12, 1909</b>
9. AGE (in years lost birthday) <b>57 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min. <b>57</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life. Even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retail Hardware</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Canada</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Patrick J. Gilmore</b>		14. MOTHER'S MAIDEN NAME <b>Georgienne Berard</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Robert Gilmore</b>	
17. INFORMANT <b>Robert Gilmore</b>		Address <b>#2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PERFORATED ULCER PERITONITIS</b> DUE TO (b) <b>2 DAYS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>DIABETES MELLITUS; HYPERTENSIVE HEART DIS.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 1966</b> to <b>8 Jan 1967</b> , that (I) (we) last saw the deceased alive on <b>Jan 1967</b> , and that death occurred at <b>1:00 P.M.</b> from causes and on the date stated above.			
21a. SIGNATURE <b>Edward S. Beck</b>		21b. DATE SIGNED <b>1/9/67</b>	
21c. PHYSICIAN'S NAME (Type) <b>Edward S. Beck, M.D.</b>		21d. ADDRESS <b>73 Franklin St., Annapolis, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIED</b>		23b. DATE THEREOF <b>11-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest</b>		23d. LOCATION (City or Town) (County) (State) <b>Annapolis Md.</b>	
24. FUNERAL DIRECTOR <b>Goku M. Laylor &amp; Sons</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 12 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
GM 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00100

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00101

1. PLACE OF DEATH a. COUNTY <u>ARMCO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>ARMCO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Miller'sville</u>		c. LENGTH OF STAY IN TB	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOR-NORTH ARUNDEL HOSP.</u>		e. STREET ADDRESS <u>372 E/M. Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>Joseph.</u> Middle <u>Goldys</u> Last <u>90/dys</u>		4. DATE OF DEATH Month <u>1</u> Day <u>5</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-29-07</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MD.</u>	9. AGE (In years last birthday) <u>59</u> YRS
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN GOLDS SR.</u>		14. MOTHER'S MAIDEN NAME <u>MARY JANKOWSKI</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES</u> <u>WW II</u>		16. SOCIAL SECURITY NO <u>—</u>	
17. INFORMANT <u>IDA WEGRYNIAK</u>		Address	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY <u>450.0</u> IMMEDIATE CAUSE (a) <u>Arteriosclerosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>Short</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhardt</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <u>1-5-67</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1/9/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Balto. Natl.</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md</u>
24. FUNERAL DIRECTOR <u>John Connelly Son</u>		ADDRESS <u>300 mace</u>	
25a. REC'D BY REGISTRAR <u>JAN 10 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Thomas Judge</u>	



## CERTIFICATE OF DEATH

00105

00102

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN it <b>Annapolis</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>		d. STREET ADDRESS <b>19 Hill Street</b>	
3. NAME OF DECEASED (Type or print) <b>Emily Ellen GRANT</b>		4. DATE OF DEATH Month <b>January</b> Day <b>18</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 21, 1891</b>
9. AGE (In years last birthday) <b>75</b> yrs		10. IF UNDER 1 YEAR Months <b>18</b> Days <b>19</b> Hours <b>67</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Printing</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Annapolis Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>William H. Taylor</b>		14. MOTHER'S MAIDEN NAME <b>Matilda Thomas</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>216-44-5552A</b>	
17. INFORMANT <b>Son- Clarence H. Grant</b>		Address <b>same as #2 above</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>331X</b> IMMEDIATE CAUSE (a) <b>VEREBRAL HEMORRHAGE, MIDDLE CER. ART.</b> DUE TO (b) <b>ATHEROSCLEROSIS</b> DUE TO (c) <b>ATHEROSCLEROSIS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1946</b> , to <b>18 Jan, 1967</b> , that (I) (we) last saw the deceased alive on <b>18 Jan 1967</b> , and that death occurred at <b>9:35 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Edward S. Beck</b>		22b. DATE SIGNED <b>1-19-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Edward S. Beck</b>		22d. ADDRESS <b>Franklin St.,</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>1/23/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Naval Academy Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Annapolis A.A. Md.</b>
24. FUNERAL DIRECTOR <b>Beverley B. Hopping</b> <b>Hopping Funeral Home - Annapolis, Md.</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

00102

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH

00103

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>FORT GEORGE G. MEADE</b> c. LENGTH OF STAY IN 1b <b>59 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>KIMBROUGH ARMY HOSPITAL</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY _____ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> d. STREET ADDRESS <b>5703 GIST AVENUE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>HELEN</b>		First <b>P.</b>		Middle <b>GRAY</b>		Last <b>GRAY</b>		4. DATE OF DEATH Month <b>JANUARY</b> Day <b>20</b> Year <b>19 67</b>	
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>NEGROID</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>15 OCT 1925</b>		9. AGE (In years last birthday) <b>41</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Prince George, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
13. FATHER'S NAME <b>Zack Todd</b>				14. MOTHER'S MAIDEN NAME <b>Hester Tucker</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>229-16-5780</b>				17. INFORMANT <b>Theodore Gray (husband)</b>				18. ADDRESS <b>Balto, Md</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>GENERALIZED METASTATIC CARCINOMA</b> Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. (c) _____				INTERVAL BETWEEN ONSET AND DEATH <b>6 MO.</b>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		20g. (County)	
20h. (State)		21. I certify that <b>1</b> (this hospital) attended the deceased from <b>23 Nov 1966</b> to <b>20 Jan 1967</b> , that <b>(X)</b> (we) last saw the deceased alive on <b>20 Jan 1967</b> , and that death occurred at <b>12:30</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Jorge J. Ramirez, CPT, MC</b>				M.D. <b>Jorge J. Ramirez, CPT, MC</b>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>20 Jan 67</b>	
22c. PHYSICIAN'S NAME (Type) <b>JORGE J. RAMIREZ, CPT, MC</b>				22d. ADDRESS <b>KIMBROUGH ARMY HOSP, FT GEO G MEADE, MD</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>B</b>		23b. DATE THEREOF <b>1/25/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>National Cemetery</b>		23d. LOCATION (City, town or county) <b>Pentagon</b>		23e. (State) <b>VA</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph L. Rous</b>				ADDRESS <b>2222 W. Prithane</b>		25a. REC'D BY REGISTRAR <b>DATE JAN 23 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

MEDICAL CERTIFICATION



00103

## CERTIFICATE OF DEATH

00104

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN TB <b>4 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Crownsville State Hospital</b>		d. STREET ADDRESS <b>Box 28-A Rt 3</b>	
3. NAME OF DECEASED (Type or print) <b>#34244 Elmer Green</b>		4. DATE OF DEATH Month <b>1</b> Day <b>10</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Sep. DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/2/02</b>
9. AGE (In years last birthday) <b>64</b> yrs.		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>10</b> Hours <b>10</b> Min <b>10</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>		12. KIND OF BUSINESS OR INDUSTRY <b>INDUSTRY</b>	
13. FATHER'S NAME <b>Edward Green</b>		14. MOTHER'S MAIDEN NAME <b>Mary Ann Burkes</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>Unknown</b>	
17. INFORMANT <b>Allice Green Edgewood Rd. Annapolis</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Liver</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Psychotic Depressive Reaction</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour <b>11</b> AM <b>11</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that (I) (this hospital) attended the deceased from <b>1/6/1967</b> , to <b>1/10/1967</b> , that (I) (we) last saw the deceased alive on <b>1/10/1967</b> , and that death occurred at <b>4:25 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>L. Benedict</b>		22b. DATE SIGNED <b>1/10/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. Benedict, M.D.</b>		22d. ADDRESS <b>Crownsville State Hospital, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>1/14/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Golden Meadows</b>	23d. LOCATION (City or town) (County) (State) <b>Annapolis Md</b>
24. FUNERAL DIRECTOR <b>William Reese Jr</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>JAN 11 1967</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1977



00104

CERTIFICATE OF DEATH

00105

1. PLACE OF DEATH a. COUNTY <u>H. A. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>M.D.</u> b. COUNTY <u>H. A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>A. A. GENERAL Hosp.</u>		d. STREET ADDRESS <u>DAVIDSONVILLE WAYSON ROAD</u>	
3. NAME OF DECEASED (Type or print) <u>MARGARET PATTERSON GREENE</u>		4. DATE OF DEATH Month <u>1</u> Day <u>15</u> Year <u>1967</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-15-1912</u>
9. AGE (In years last birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>St. of Md.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>ANNAPOLIS, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William B. Patterson</u>		14. MOTHER'S MAIDEN NAME <u>Minnie M. Mouhan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>WM H. GREENE #2</u>		Address <u>  </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>443X</u> IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>  </u> (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>8 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1959</u> , to <u>Jan</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Jan 10</u> 19 <u>67</u> , and that death occurred at <u>9A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Francis I. Codd</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>1-16-67</u>
22c. PHYSICIAN'S NAME (Type) <u>Francis I. Codd M.D.</u>		22d. ADDRESS <u>Severna Park, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>1-18-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Marys</u>	23d. LOCATION (City or Town) (County) (State) <u>ANNAPOLIS H. A. MD.</u>
24. FUNERAL DIRECTOR <u>John M. LeFors &amp; Sons</u>		ADDRESS <u>ANNAPOLIS, MD.</u>	25a. REC'D BY REGISTRAR <u>DATA 18 1967</u>
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



00105

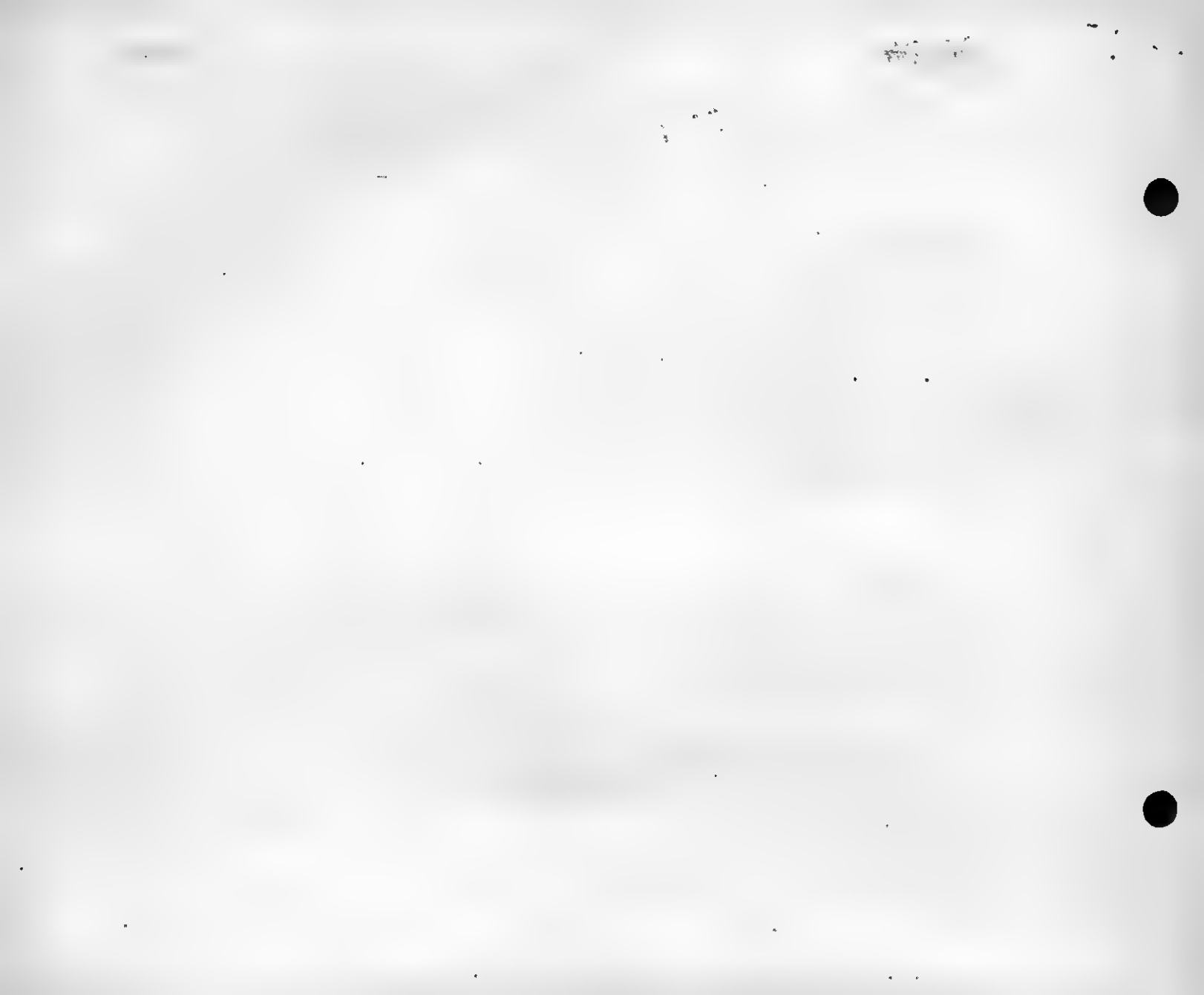
## CERTIFICATE OF DEATH

00106

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - GLEN BURNIE</b>		c. LENGTH OF STAY IN lb <b>10 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - GLEN BURNIE</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>NORTH ARUNDEL HOSPITAL</b>				d. STREET ADDRESS <b>97 ELM AVE GARLAND PARK</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>GREENWALD</b> Last <b>GREENWALD</b>				4. DATE OF DEATH Month <b>JANUARY</b> Day <b>19</b> Year <b>1967</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 8 1891</b>		9. AGE (In years last birthday) <b>75</b> yrs	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>APT. SUPT.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MAINTENANCE</b>		11. BIRTHPLACE (County & State, or foreign country) <b>AUSTRIA</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>Anthony Greenwald</b>				14. MOTHER'S MAIDEN NAME <b>Rosine Regget</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>056/10/4298</b>		17. INFORMANT Address <b>Mrs. Helma A. Greenwald Same as #2</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY <b>4/21/1</b> IMMEDIATE CAUSE (a) <b>AS HD</b> DUE TO <b>Congestive Heart failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>Thrombosis, right auricle</b> (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (H) (this hospital) attended the deceased from <b>1/19/67</b> , 19 to <b>1/19/67</b> , 19, that (I) (we) last saw the deceased alive on <b>1/18</b> 19 <b>67</b> , and that death occurred at <b>11:40</b> M, from causes and on the date stated above.							
22a. SIGNATURE <b>J. B. Ramirez</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1/19/67</b>			
22c. PHYSICIAN'S NAME (Type) <b>J. B. RAMIREZ MD</b>		22d. ADDRESS <b>1672 North Burnie Rd Baltimore 12 Md 3527 ANNAPOLIS RD Baltimore Md</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan. 23, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Glen Burnie, Md.</b>	
24. FUNERAL DIRECTOR <b>R.V. SINGLETON</b>				ADDRESS <b>GLEN BURNIE, MD.</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 24 1967</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00106					00107				
1. PLACE OF DEATH a. <u>Arundel</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>			c. LENGTH OF STAY IN 1B <u>Life</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RFD # 7 Pasadena</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>North Arundel Hospital</u>					d. STREET ADDRESS <u>Treetop Farm</u>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mary</u>		First		Middle <u>C.</u>		Last <u>Groom</u>		4. DATE OF DEATH Month <u>1</u> Day <u>2</u> Year <u>1967</u>	
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-28-79</u>		9. AGE (In years last birthday) <u>87</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>George Wilbert Wilson</u>					14. MOTHER'S MAIDEN NAME <u>Christine Sellers</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Family Records</u>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>peritonitis</u> <u>1950</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>intestinal obstruction</u> DUE TO (c) <u>Carcinoma of ascending colon</u>									INTERVAL BETWEEN ONSET AND DEATH <u>Days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>12-19</u> , 19 <u>66</u> , to <u>1-2</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1-1</u> , 19 <u>66</u> , and that death occurred at <u>6:10 AM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>E. A. Tolentino</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1-2-67</u>
22c. PHYSICIAN'S NAME (Type) <u>E. A. TOLENTINO, M.D.</u>					22d. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 5, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Parkville, Maryland</u>		
24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Maryland</u>					25a. REC'D BY REGISTRAR DATE <u>JAN 9 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

MEDICAL CERTIFICATION



00107

## CERTIFICATE OF DEATH

00108

1. PLACE OF DEATH a. COUNTY <u>Adams</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Adams</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chickadee</u>		c. LENGTH OF STAY IN TB	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Chickadee Terminal</u>		e. STREET ADDRESS <u>Salisbury</u>	
3. NAME OF DECEASED (Type or print) <u>Webster</u> First <u>Gross</u> Last		4. DATE OF DEATH Month <u>Jan</u> Day <u>7</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-1-1894</u> yrs. <u>72</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Elie Gross</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Reed</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes WWII</u>		16. SOCIAL SECURITY NO <u>217-07-388</u>	
17. INFORMANT <u>William Jackson Salisbury</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO (b) <u>Hypertensive Cardiovascular disease</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>Years</u>	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 7</u> , 19 <u>67</u> to <u>Jan 7</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>Jan 7</u> , 19 <u>67</u> , and that death occurred at <u>3 P</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>William F. Smith</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>1/8/67</u>
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1-12-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cherry Mount</u>	23d. LOCATION (City or town) (County) (State) <u>Onionsville MD</u>
24. FUNERAL DIRECTOR <u>William Reese #121201</u>		25a. REC'D BY REGISTRAR DATE <u>10 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



00108

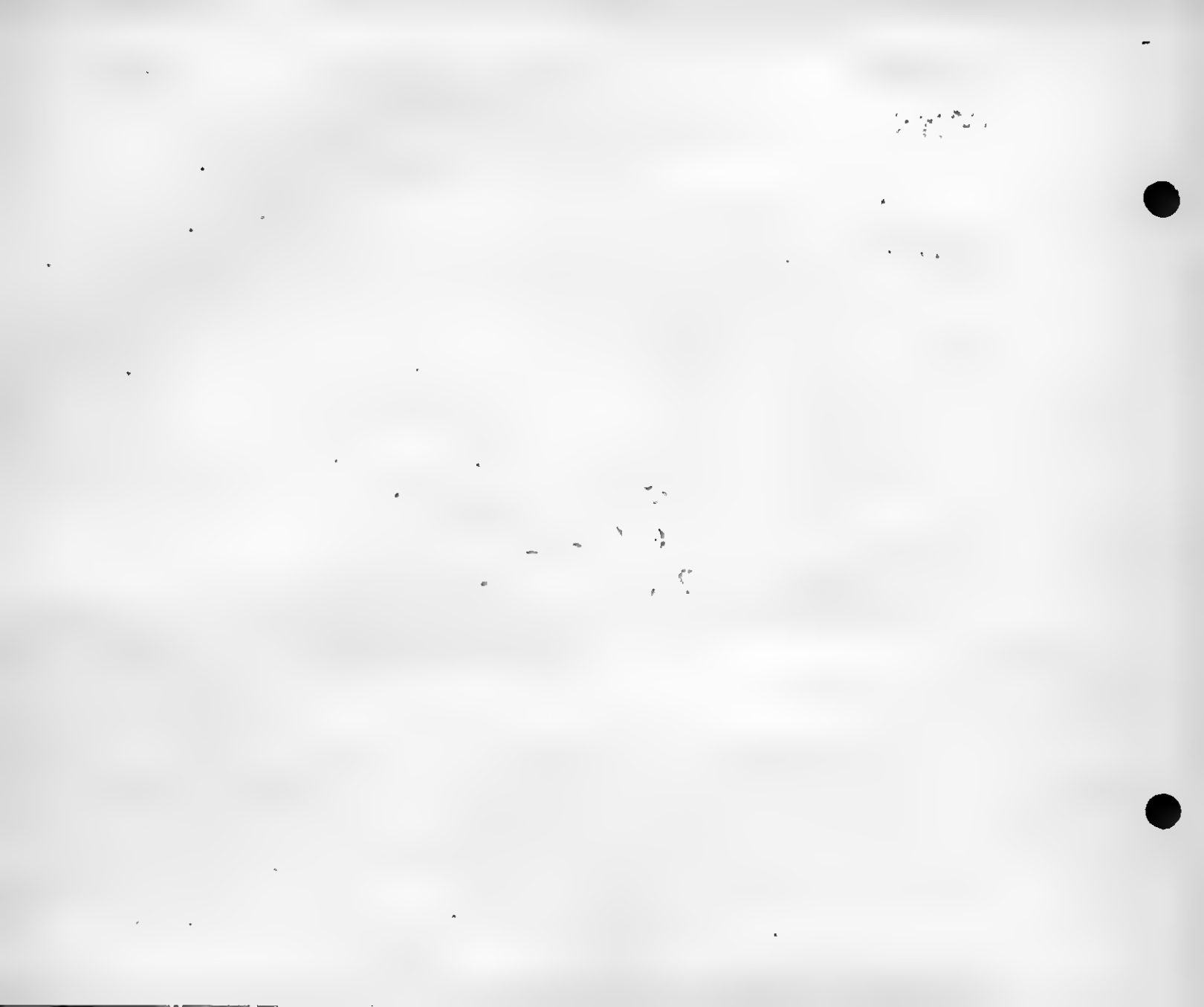
CERTIFICATE OF DEATH

00109

1 PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut an: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>	c. LENGTH OF STAY in lb <u>4</u> Days d	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <del>XXXX</del> <u>Glen Burnie</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Arundel Hospital</u>		d. STREET ADDRESS <u>500 Broadway Blvd., Ferndale, Glen Burnie Md.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) <u>John</u> First <u>Hammons</u> Middle <u>(nmi)</u> Last		4 DATE OF DEATH <u>Jan 1</u> Month <u>1</u> Day <u>67</u> Year	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>9-20-1900</u>
9. AGE (In years last birthday) yrs <u>66</u>		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life - even if retired) <u>Retired Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Laborer</u>	11. BIRTHPLACE (County & State, or foreign country) <u>West Virginia</u>
12. CITIZEN OF WHAT COUNTRY? <u>United States</u>		13. FATHER'S NAME <u>Pete Hammons</u>	
14. MOTHER'S MAIDEN NAME <u>Emily Fowler</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u> <u>none</u>	
16. SOCIAL SECURITY NO. <u>232-221938-A</u>		17. INFORMANT <u>Mrs. Jean Miller (Daughter)</u> Same as #2 Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Empty stomach</u> <u>5271</u> DUE TO <u>A S H D</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>? Pneumonia</u> (c)			INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 8</u> , 1966, to <u>Jan 1</u> , 1967, that (I) (we) last saw the deceased alive on <u>Jan 1</u> 1967, and that death occurred at <u>7:15</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Robert Jabolins</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT JABOLINS, M.D.</u>		22d. ADDRESS <u>400 Gainsburg Ave Glen Burnie, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Jan. 5, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Haven Mem. Park</u>	23d. LOCATION (City or Town) (County) (State) <u>Glen Burnie, Md.</u>
24. FUNERAL DIRECTOR <u>R.V. Singleton</u>		25a. REC'D BY REGISTRAR DATE <u>MAY 19 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISME (5)  
SM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH										
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND										
00109 MEDICAL EXAMINER'S CERTIFICATE OF DEATH					00110					
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glen Burnie			c. LENGTH OF STAY IN 1b 5 wks.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glen Burnie					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) North Arundel Hospital					d. STREET ADDRESS 1250 Aster Dr.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First ELLA Middle J. Last HARRIS					4. DATE OF DEATH Month Jan. Day 8 Year 19 67					
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2 June 1887		9. AGE (In years last birthday) 79 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Lake City - Tenn.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME (unknown)					14. MOTHER'S MAIDEN NAME (unknown)					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 212-4D-8166		17. INFORMANT Address T(William J. Bratcher - Same as # 2						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>BRONCHIAL PNEUMONIA</i> H/1111 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <i>ARTERIO SCLEROSIS</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>fracture hip R</i>									INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>fall from house</i>								
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <i>Robert P. W...</i> EXAMINER'S NAME (Type) ELMER G. LINHARDT, Annapolis, Md.					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					22. DATE SIGNED 1/8/67
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/11/67		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Pk.		23d. LOCATION (City, town or county) (State) Glen Burnie, Maryland				
24. FUNERAL DIRECTOR Address Singleton Funeral Home/Glen Burnie, Maryland					25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JAN 11 1967 <i>Johanna Judge</i>					

87.1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

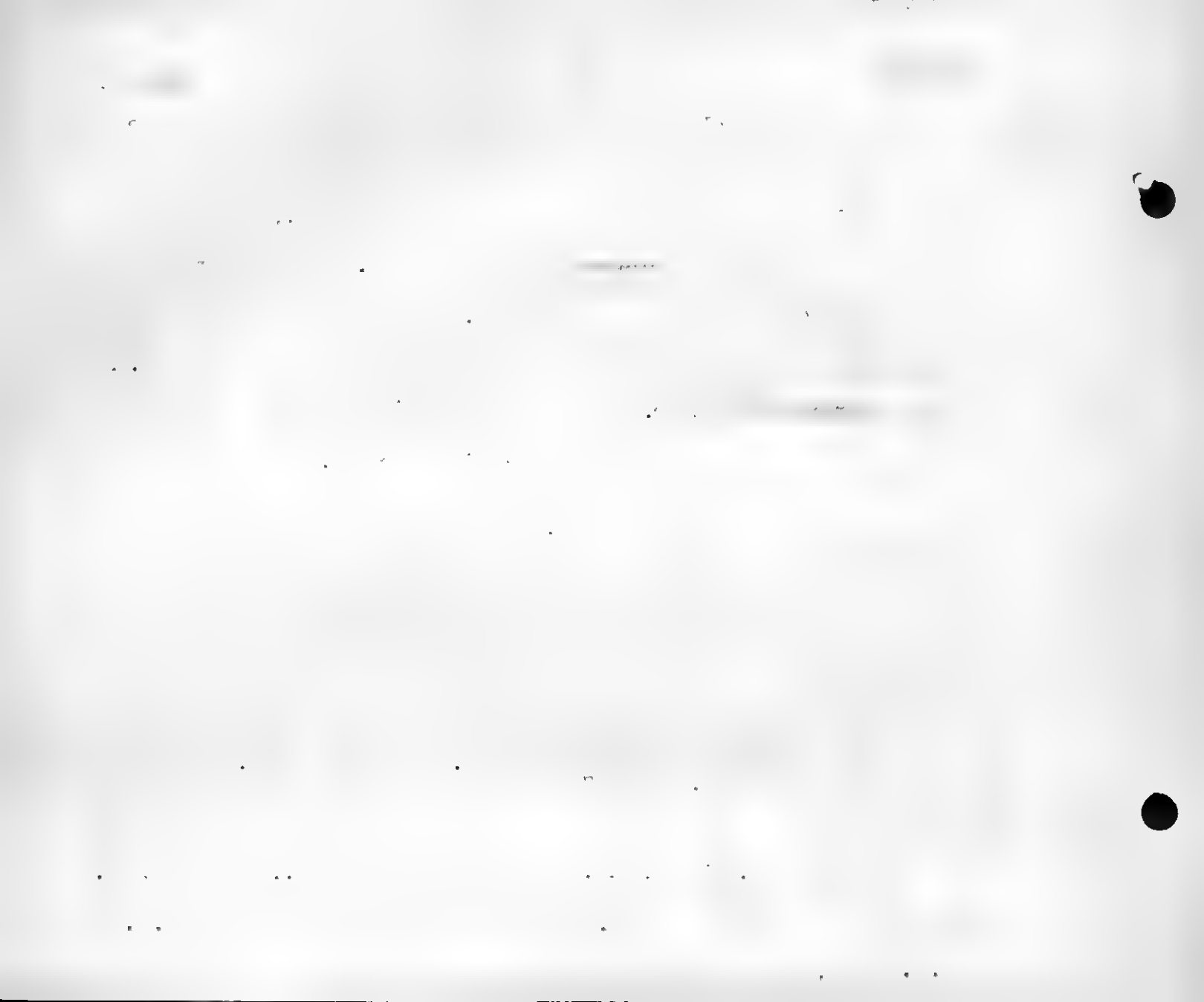
00110

00111

1 PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>12 hrs</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>		d. STREET ADDRESS <b>9 Poplar Ave.,</b>	
3 NAME OF DECEASED (Type or print) <b>Douglas Lawrence</b>		4 DATE OF DEATH Month <b>January</b> Day <b>14</b> Year <b>1967</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 14, 1967</b>
9 AGE (In years lost birthday) yrs <b>12</b>		10. IF UNDER 1 YEAR Months <b>12</b> Days <b>25</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Anne Arundel, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Douglas Lawrence Hawkins, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Mary Catherine Ross</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Hospital records.</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Respiratory failure</b> DUE TO <b>Immaturity</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) INTERVAL BETWEEN ONSET AND DEATH <b>12 hr</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS A TOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (I) <del>did not</del> attended the deceased from <b>Jan. 14, 1967</b> , to <b>Jan. 14, 1967</b> , that (I) <del>did not</del> saw the deceased alive on <b>Jan. 14, 1967</b> , and that death occurred at <b>11:45 PM</b> , from causes and on the date stated above			
22a SIGNATURE <b>Antonio M. Rivera, M.D.</b>		22b DATE SIGNED <b>17 Jan 67</b>	
22c PHYSICIAN'S NAME (Type) <b>Antonio M. Rivera, M.D.</b>		22d ADDRESS <b>SouthRivMedCent., Edgewater, Md.</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b DATE THEREOF <b>1/16/67</b>	23c NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary</b>	23d LOCATED ON (City or Town) (County) (State) <b>Arnold A.A.Co Md</b>
24. FUNERAL DIRECTOR <b>C.E. Hicks, III</b>		25a. REC'D BY REGISTRAR <b>Frederick, Md</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>JAN 20 1967</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



00115

## CERTIFICATE OF DEATH

00115

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN lb <b>D.O.A.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Dead on arrival Anne Arundel General Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - Annapolis</b>	
3. NAME OF DECEASED (Type or print) <b>Winifred</b> First <b>WELLS</b> Middle <b>HEARD</b> Last		4. DATE OF DEATH Month <b>January</b> Day <b>4</b> Year <b>19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-7-1893</b>
9. AGE (In years last birthday) yrs <b>73</b>		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>19</b> Hours <b>67</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Mt. HARMONY, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>WILLIAM WELLS</b>		14. MOTHER'S MAIDEN NAME <b>AGNES LANE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>MR. CHAS. D. HEARD #2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <b>331X</b> IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b> DUE TO (b) <b>Cerebral atherosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I. of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) <del>physician</del> attended the deceased from <b>2/19, 1962</b> to <b>12/13, 1966</b> that (I) <del>see</del> saw the deceased alive on <b>12/13, 1966</b> , and that death occurred at <b>8:20 PM</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Richard I. Hochman</b> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>1/5/67</b>
22c. PHYSICIAN'S NAME (Type) <b>Richard I. Hochman, M.D.</b>		22d. ADDRESS <b>59 Franklin St., Annapolis, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>1-7-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>HILLCREST CEM.</b>	23d. LOCATION (City or Town) (County) (State) <b>ANNAPOLIS MD.</b>
24. FUNERAL DIRECTOR <b>JOHN M. TAYLOR SONS ANNAPOLIS MD.</b>		25a. REC'D BY REGISTRAR <b>DATE JAN 10 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE  
HEALTH DEPT.

00112

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00113

1 PLACE OF DEATH a COUNTY <b>Anne Arundel</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if inst. tut on Residence before adm ssion) a STATE <b>Maryland</b> b COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Jessup</b>		c LENGTH OF STAY IN 1b <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Maryland House of Correction</b>		d STREET ADDRESS <b>2836 Sixth St.</b>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>HARRY W. HINKLE, Jr.</b>		4 DATE OF DEATH Month Day Year <b>January 17 19 67</b>	
5 SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 12, 1923</b>
9 AGE (In years last birthday) <b>43</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min. <b>43</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Guard</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Security</b>	
11 BIRTHPLACE (State or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Harry W. Hinkle</b>		14. MOTHER'S MAIDEN NAME <b>Nora Bennaman</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO	
17. INFORMANT <b>Mrs. Nora Hinkle - 3836 Sixth St., Baltimore</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>420.0</b> IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease.</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion a death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Charles S. Petty</i>		22. DATE SIGNED <b>1/18/67</b>	
EXAMINER'S NAME (Type) <b>Charles S. Petty</b>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>1-21-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Memorial Pk.</b>	23d. LOCATION (City or Town) (County) (State) <b>Ritchie Hwy., A.A. Co., Md.</b>
24. FUNERAL DIRECTOR <b>George J. Gonce-4001 Ritchie Hwy., Baltimore</b>		25a. REC'D BY REGISTRAR <b>JAN 23 1967</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 3 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00113

CERTIFICATE OF DEATH

00114

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL- GLEN BURNIE</b>		c. LENGTH OF STAY IN 1b <b>58 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>NORTH ARUNDEL HOSPITAL</b>		d. STREET ADDRESS <b>RT.2 BOX 174</b>	
3. NAME OF DECEASED (Type or print) First <b>GOODIN</b> Middle <b>EDWARD</b> Last <b>HINSON</b>		4. DATE OF DEATH Month <b>JANUARY</b> Day <b>4</b> Year <b>1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 16, 1889</b>
9. AGE (In years last birthday) <b>77 yrs</b>		10. IF UNDER 1 YEAR Months <b>77</b> Days <b>77</b> Hours <b>77</b> Min <b>77</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <b>CHAUFFEUR-RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>DRYCLEANING</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>ALBERNARLE, NOTRH CAROLINA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Frank Hinson</b>		14. MOTHER'S MAIDEN NAME <b>Shara (unknown)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>214-01-1683</b>	
17. INFORMANT <b>VIRGINIA GRIFFIN</b>		Address <b>RT 2 BOX 174 MILLERSVILLE</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Arteriosclerosis</b> DUE TO <b>Arteriosclerosis general</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis general</b> (c) <b>Arteriosclerosis general</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 1966</b> to <b>Jan 4, 1967</b> , that (I) (we) last saw the deceased alive on <b>Jan 3 1966</b> and that death occurred at <b>2:15 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Joseph Taler</b>		22b. DATE SIGNED <b>Jan 4, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOSEPH TALER</b>		22d. ADDRESS <b>95 Aqueduct Rd. Glen Burnie, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Jan. 7, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Carolina Memorial Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Concord N. Carolina</b>
24. FUNERAL DIRECTOR <b>R.V. Singleton</b>		25a. REC'D BY REGISTRAR <b>JAN 9 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		25c. REGISTRAR'S SIGNATURE <b>[Signature]</b>	



# FOR STATE HEALTH DEPT.

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VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00114

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00115

1 PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Glen Burnie</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie-rural</b>		c. LENGTH OF STAY IN 1b <b>25 yrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>North Arundel Hospital</b>		d. STREET ADDRESS <b>Rt. 10 Box 106 Lake Shore</b>	
3 NAME OF DECEASED (Type or print) First <b>Bernard</b> Middle <b>J.</b> Last <b>Holmes</b>		4 DATE OF DEATH Month <b>1</b> Day <b>17</b> Year <b>19 67</b>	
5 SEX <b>male</b>	6 COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/29/1908</b>
9 AGE (In years last birthday) <b>58 yrs</b>		IF UNDER 1 YEAR Months <b>7</b> Days <b>18</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Insurance</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Insurance</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Thomas Joseph Holmes Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Curley</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>213-28-5676</b>	
17. INFORMANT <b>Margaret Holmes (Wife)</b>		Address <b>As Above</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY <b>819.4</b> IMMEDIATE CAUSE (a) <b>Steering wheel injury of chest with transection of aorta</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>DUE TO</b> (c) <b></b>			INTERVAL BETWEEN ONSET AND DEATH <b></b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b></b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) <b>driver in auto-fixed object collision</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>?</b> p.m. <b>1 17 1967</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>street</b>
20f. (City or town) <b>Glen Burnie</b>		(County) <b>A.A.</b>	(State) <b>Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Werner U. Spitz</b>		22. DATE SIGNED <b>1/17/67</b>	
EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b>		Address (Street, city, town, or county) <b></b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>1/20/1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem. Park</b>	23d. LOCATION (City or Town) (County) (State) <b>Glen Burnie, Md.</b>
24 FUNERAL DIRECTOR <b>Raymond C. Fink</b>		25a. REC'D BY REGISTRAR <b>J. Charles Judge</b>	
ADDRESS <b>Glen Burnie, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	
DATE <b>JAN 19 1967</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 2 Film G382 1/20/67 mh

00115

CERTIFICATE OF DEATH

00116

1 PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. LENGTH OF STAY IN lb <u>ANNAPOLIS MD</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ANNAPOLIS NURSING HOME</u>		e. STREET ADDRESS <u>1202 Sterling Drive</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Nettie M. Harleman</u>		4. DATE OF DEATH Month Day Year <u>JAN 21 1967</u>	
5 SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>JUNE 17, 1880</u>
9 AGE (In years last birthday) <u>86</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>JAMES MANDERS</u>		14 MOTHER'S MAIDEN NAME <u>EMMA SOMMERS</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO <u>212-16-7380A</u>	
17 INFORMANT <u>ANNAPOLIS NURSING HOME</u>		Address <u>VIA BLUE RIDGE</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Dehydration; Infected Decubiti;</u> <u>4221</u> DUE TO (b) <u>Severe A.S.C.V.D.; Chron. brain syndrome</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			INTERVAL BETWEEN ONSET AND DEATH <u>7 weeks</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>Recent left hip fracture. Degenerative Osteoarthritis</u>			9 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) <u>Hip fracture was Spontaneous.</u>	
20c TIME OF INJURY Month, Day, Year Hour am p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 1966, to <u>Jan 20</u> , 1967 that (I) <u>was</u> last saw the deceased alive on <u>Jan 20</u> , 1967, and that death occurred at <u>9 P. M.</u> from causes and on the date stated above.			
22a SIGNATURE <u>Peter F. Verkouwen</u>		22b DATE SIGNED <u>1-21-1967</u>	
22c PHYSICIAN'S NAME (Type) <u>PETER F. VERKOUWEN, MD</u>		22d ADDRESS <u>1407 FOREST DRIVE ANNAPOLIS, MD</u>	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF <u>1-25-67</u>	23c NAME OF CEMETERY OR CREMATORY <u>OXFORD CEMT.</u>	23d LOCATION (City or Town) (County) (State) <u>OXFORD MD.</u>
24 FUNERAL DIRECTOR <u>John A. Laffoon</u>		25a REC'D BY REGISTRAR DATE <u>JAN 24 1967</u>	
		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician. Page 5 is retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and file them with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00116

00117

1. PLACE OF DEATH a. COUNTY <b>ANN ARUNDEL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANN ARUNDEL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GLEN BURNIE</b>		c. LENGTH OF STAY IN Tb <b>Box 324</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>NORTH ARUNDEL GENERAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>SAMUEL ELIZAH HOWARD</b>		4. DATE OF DEATH Month Day Year <b>JAN 24 1967</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>N</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN 20 1924</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (County, State, or foreign country) <b>ARUNDEL Co Md.</b>	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>SAMUEL E HOWARD SR.</b>		14. MOTHER'S MAIDEN NAME <b>ANNIE BLAND</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO <b>HILDA HOWARD</b>	
17. INFORMANT <b>HILDA HOWARD</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MASSIVE CEREBRAL HEMORRHAGE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <b>MALIGNANT HYPERTENSION</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH <b>SUDEN</b> <b>3 YRS.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1964</b> to <b>1967</b> , that (I) (we) last saw the deceased alive on <b>JAN 7 1967</b> , and that death occurred at <b>2:25 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Arthur Lankford Jr.</b>		22b. DATE SIGNED <b>1-24-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>ARTHUR LANKFORD, JR., M. D.</b>		22d. ADDRESS <b>1934 Mountain Rd Pasadena, Md. 21122</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>1-28-1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>MOUNT CALVARY</b>		23d. LOCATION (City, town or county) (State) <b>ARUNDEL Co Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>I. L. BROWN + SON</b>		25a. REC'D BY REGISTRAR <b>JAN 27 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

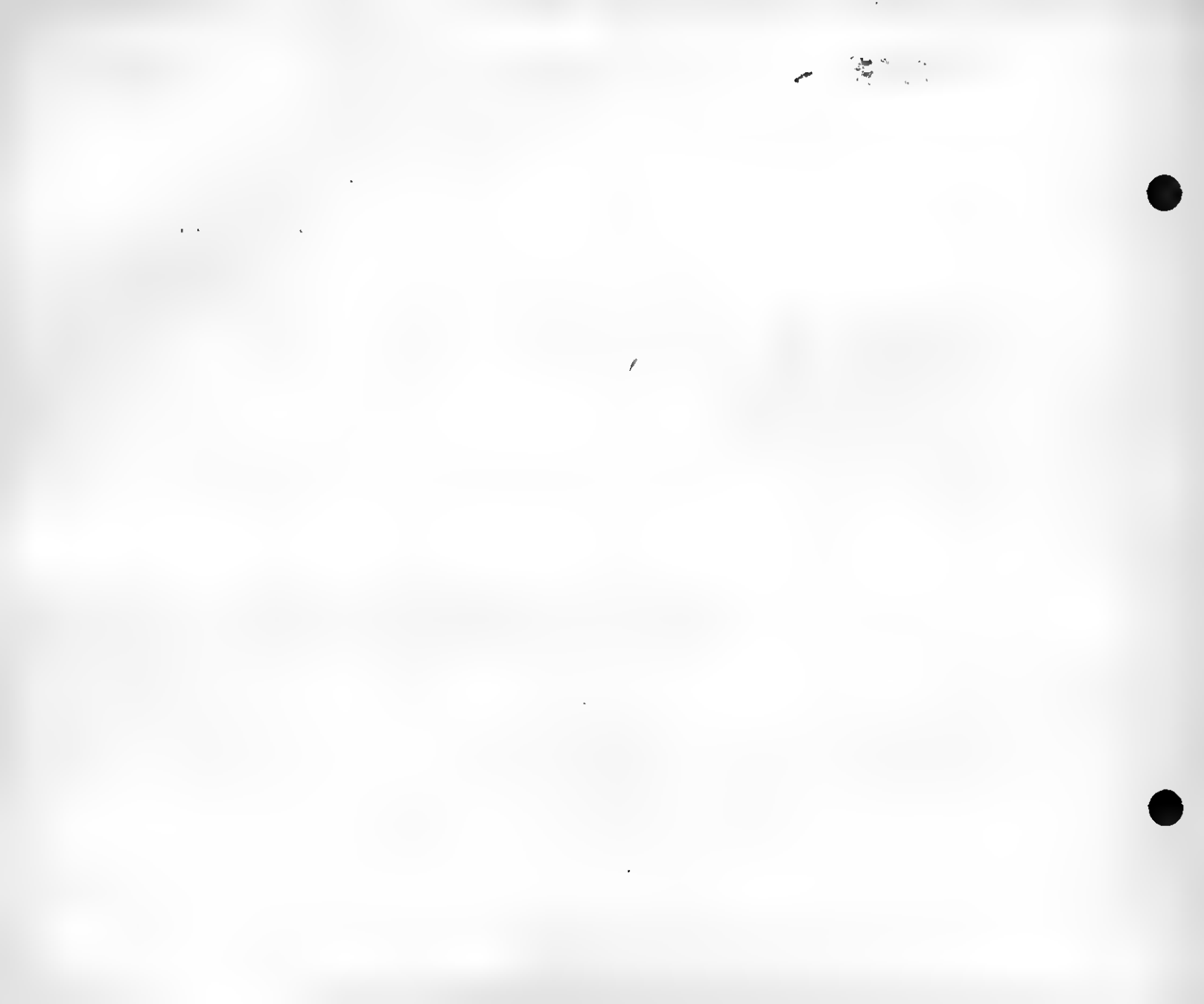
00117

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00118

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1 PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> 30.4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>North Arundel General</b>		d. STREET ADDRESS <b>102 E. Fort Ave.</b>	
3 NAME OF DECEASED (Type or print) First <b>Jordan</b> Middle <b>Hutto</b> Last _____		4 DATE OF DEATH Month <b>1</b> Day <b>8</b> Year <b>1967</b>	
5 SEX <b>male</b>	6 COLOR OR RACE <b>white</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>12/1/1905</b>
9 AGE (In years last birthday) <b>61</b> yrs		10 IF UNDER 1 YEAR Months _____ Days _____	
10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>Don Worker - Don Worker Union</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Don Worker Union</b>	
11 BIRTHPLACE (State or foreign country) <b>Texas</b>		12 CITIZENSHIP OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>Unknown</b>		14 MOTHER'S MAIDEN NAME <b>Unknown</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <b>yes</b> <b>World War II</b>		16 SOCIAL SECURITY NO. <b>457-18-5943</b>	
17 INFORMANT <b>Edna Hutto</b>		Address <b>(-above-)</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Drowning</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Driver of auto which ran off roadway into shallow water</b>	
20c TIME OF INJURY Month, Day, Year Hour a.m. <b>3:00</b> P.M. <b>1</b> <b>8</b> <b>1967</b>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>water</b>	20f (City or town) (County) (State) <b>Annapolis A.A. Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Werner U. Spitz</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Werner U. Spitz M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
		Address (Street, city, town, or county)	
22. DATE SIGNED <b>1/9/67</b>			
23a BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>	23b DATE THEREOF <b>1/12/67</b>	23c NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>	23d LOCATION (City or town) (County) (State) <b>5501 Frederick Ave. Md.</b>
24 FUNERAL DIRECTOR <b>John J. Cowan &amp; Son, Inc.</b>		25a REC'D BY REGISTRAR <b>Stollins</b>	
		25b REGISTRAR'S SIGNATURE <b>John J. Cowan</b>	
		DATE <b>Jan 10 1967</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND			
00118		00119	
CERTIFICATE OF DEATH			
1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b> c. LENGTH OF STAY IN 1b -- d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>North Arundel Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution? Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>191 Millersville</b> d. STREET ADDRESS <b>61 Rol Park Trailer Village</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>David C. Ingraham</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>13</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-10-66</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	9. AGE (In years last birthday) yrs. <b>3</b> Months <b>3</b> Days <b>3</b> Hours <b>Min.</b>
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland - Balt City</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>David L. Ingraham</b>		14. MOTHER'S MAIDEN NAME <b>Joyce M. Feeney</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mr. David Lee Ingraham (Father)</b>		Address <b>Same as 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>INTERSTITIAL PNEUMONITIS</b> <b>500X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DUE TO</b> (c) <b>DUE TO</b> INTERVAL BETWEEN ONSET AND DEATH <b>SEVERAL HOURS</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>OCT 10, 1966</b> to <b>JAN 13, 1967</b> that (I) (we) last saw the deceased alive on <b>JAN 10, 1967</b> and that death occurred at <b>8:50 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Alvin W. Hecker</b>		22b. DATE SIGNED <b>JAN 13 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>ALVIN W. HECKER</b>		22d. ADDRESS <b>407 CRAW HWY SW GLEN BURNIE</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan. 13, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem. Park</b>		23d. LOCATION (City, town or county) (State) <b>Howard Co. Md.</b>	
24. FUNERAL DIRECTOR <b>Robert P. ...</b> <b>Singleton Funeral Home</b>		25a. REC'D BY REGISTRAR <b>JAN 18 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



THE UNITED STATES OF AMERICA

OFFICE OF THE SECRETARY OF DEFENSE  
WASHINGTON, D.C. 20301-6000  
ATTENTION: ASST. SEC. (P&A)  
MAIL ROOM

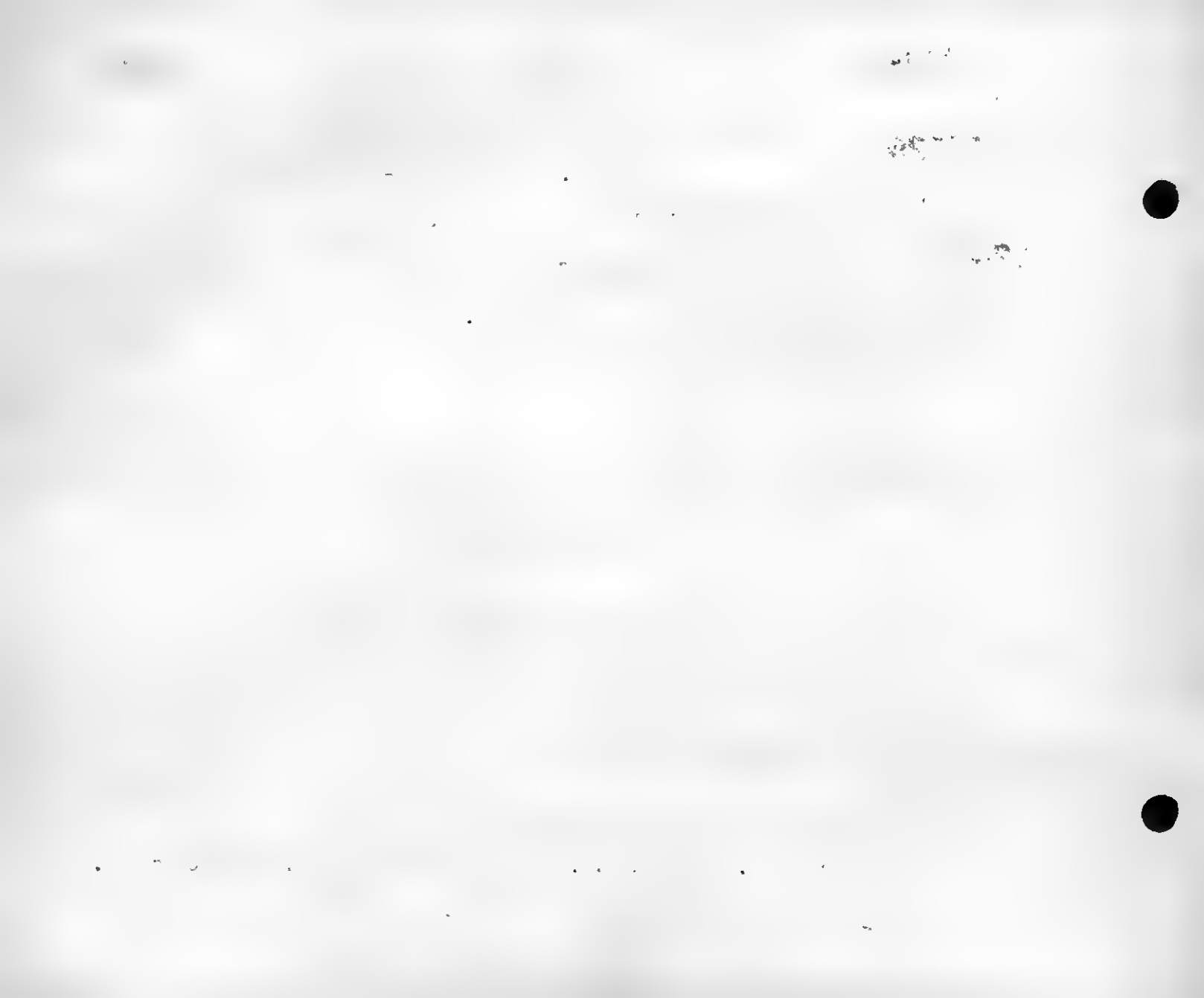
CERTIFICATE OF DEATH

00119

00120

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. LENGTH OF STAY IN 1b <b>35 min.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>(Expired in Emergency room) Anne Arundel General Hospital</b>				d. STREET ADDRESS <b>Rt-1, Box-208</b>			
3. NAME OF DECEASED (Type or print) <b>Any Woodruff JANSSENS</b>				4. DATE OF DEATH Month <b>January</b> Day <b>26</b> Year <b>19 67</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 20, 1894</b>	
9. AGE (In years last birthday) yrs. <b>72</b>		IF UNDER 1 YEAR Months <b>26</b> Days <b>19</b> Hours <b>67</b> Min		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SECRETARY</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>STEEL Co</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>BALTO, Md.</b>				12. CITIZEN OF WHAT COUNTRY <b>USA</b>			
13. FATHER'S NAME <b>WOODRUFF</b>				14. MOTHER'S MAIDEN NAME <b>IDA WESCOT</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Doc. W. JANSSENS - ABOVE</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>unknown</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour "a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>4</b> , 1966, to <b>1/26</b> , 1967 that (I) <del>(the hospital)</del> saw the deceased alive on <b>1/9</b> , 1967 and that death occurred at <b>8:25 PM</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Richard I. Hochman, M.D.</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1/27/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Richard I. Hochman, M.D.</b>				22d. ADDRESS <b>59 Franklin St., Annapolis, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
<b>Burial</b>		<b>1-30-67</b>		<b>MEADOWRIDGE</b>		<b>DORSEY Howard Md.</b>	
24. FUNERAL DIRECTOR <b>Robert S. Barranco, Severna Park, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>JAN 31 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00120

## CERTIFICATE OF DEATH

00121

1 PLACE OF DEATH a. COUNTY <u>H. A. Co.</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Res. before admission) a. STATE <u>MD.</u> b. COUNTY <u>H. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ST. MARGARETS</u>		c. LENGTH OF STAY IN TB	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BAY MANOR Nursing HOME</u>		e. STREET ADDRESS <u>55 EAST ST.</u>	
3 NAME OF DECEASED (Type or print) <u>SARAH EVA JARRELL</u>		4 DATE OF DEATH Month <u>1</u> Day <u>28</u> Year <u>1967</u>	
5 SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>2-24-1882</u>
9 AGE (in years last birthday) <u>84</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>HENDERSON MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13 FATHER'S NAME <u>William Pritchett</u>		14 MOTHER'S MAIDEN NAME <u>SARAH SPENCE</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17 INFORMANT <u>ALEX JARRELL</u>		Address <u>#2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>493X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis, generalized, chronic, that underlies</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21 I certify that (1) (this hospital) attended the deceased from <u>1/22</u> , 19 <u>67</u> , to <u>1/28</u> , 19 <u>67</u> , that (1) (two) last saw the deceased alive on <u>1/26</u> , 19 <u>67</u> , and that death occurred at <u>10:30 P.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Richard C. Plachman</u> M.D.		22b. DATE SIGNED <u>1-30-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>R. I. HOCHMAN</u>		22d. ADDRESS <u>FRANKLIN ST. ANNAPOLIS, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1-31-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>GREENSBORO, MD.</u>		23d. LOCATION (City or Town) (County) (State) <u>GREENSBORO MD.</u>	
24. FUNERAL DIRECTOR <u>John M. Taylor &amp; Sons</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 1 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>			



FOR STATE  
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY <b>Anne Arundel</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Anne Arundel</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>		c LENGTH OF STAY IN 1b <b>Jessup</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>North Arundel General Hospital</b>		e IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
3. NAME OF DECEASED (Type or print) <b>CLARENCE W. JOHNSON Sr.</b>		4 DATE OF DEATH Month Day Year <b>1 10 19 67</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Dec. 11, 1923</b>
9 AGE (In years lost birthday) yrs <b>43</b>		10 UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Gas Station Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self-Empl.</b>	
11 BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>Norman L. Johnson</b>		14. MOTHER'S MAIDEN NAME <b>Anna V. Davis</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>217/14/6134</b>	
17 INFORMANT <b>Mrs Eleanor G. Johnson</b>		Address <b>Same as # 2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Exertion during scuffle and apparent neck injury</b>			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Died about 15 minutes after scuffle</b>	
20c TIME OF INJURY Month, Day, Year <b>6-8:30 p.m. 1 10 19 67</b>	20d INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc) <b>Home &amp; Street</b>	20f (City or town) (County) (State) <b>Glen Burnie A.A. Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Rudiger Breiteneker, M.D.</b>		22. DATE SIGNED <b>1/11/67</b>	
EXAMINER'S NAME (Type) <b>Rudiger Breiteneker, M.D.</b>		Address (Street, city, town, or county)	
23a BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>	23b DATE THEREOF <b>Jan. 14, 1967</b>	23c NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem'l Park</b>	23d LOCATION (City or Town) (County) (State) <b>Glen Burnie, Md.</b>
24 FUNERAL DIRECTOR <b>R.V. SINGLETON</b>		25a REC'D BY REGISTRAR <b>JAN 13 1967</b>	
ADDRESS <b>GLEN BURNIE, MD.</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If city delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

00122

00123

1. PLACE OF DEATH a. COUNTY <u>Annapolis</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>23 Wilson Road</u>		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Annapolis</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> d. STREET ADDRESS <u>23 Wilson Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Henry Johnson</u> First Middle Last 4. DATE OF DEATH Month <u>1</u> Day <u>26</u> Year <u>1967</u>		5. SEX <u>Male</u> 6. COLOR OR RACE <u>Col.</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>7-4-1891</u> 9. AGE (In years last birthday) <u>75</u> yrs. IF UNDER 1 YEAR Months <u>7</u> Days <u>5</u> IF UNDER 24 HRS. Hours <u>1</u> Min. <u>26</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Charles H Johnson</u> 14. MOTHER'S MAIDEN NAME <u>Sannie Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>215-09-0883</u> 16. SOCIAL SECURITY NO. <u>215-09-0883</u> 17. INFORMANT <u>Rebecca Johnson</u> Address <u>Annap. Md.</u>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Hypertensive Cardio Vascular</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Disease</u> (e), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July 1965</u> to <u>Jan. 26, 1967</u> that (I) (we) last saw the deceased alive on <u>Jan. 26, 1967</u> , and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>R. L. Richardson</u> 22c. PHYSICIAN'S NAME (Type) <u>R. L. Richardson, M.D.</u>		22b. DATE SIGNED <u>1-28-67</u> 22d. ADDRESS <u>110 Clay St., Annapolis, Md., 21401</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>1-30-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fowlers</u> 23d. LOCATION (City, town or county) (State) <u>Best Gate Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William Keeseff</u> ADDRESS <u>Annap. Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 30 1967</u> 25b. REGISTRAR'S SIGNATURE <u>W. Keeseff</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of this certificate should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers as 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00123

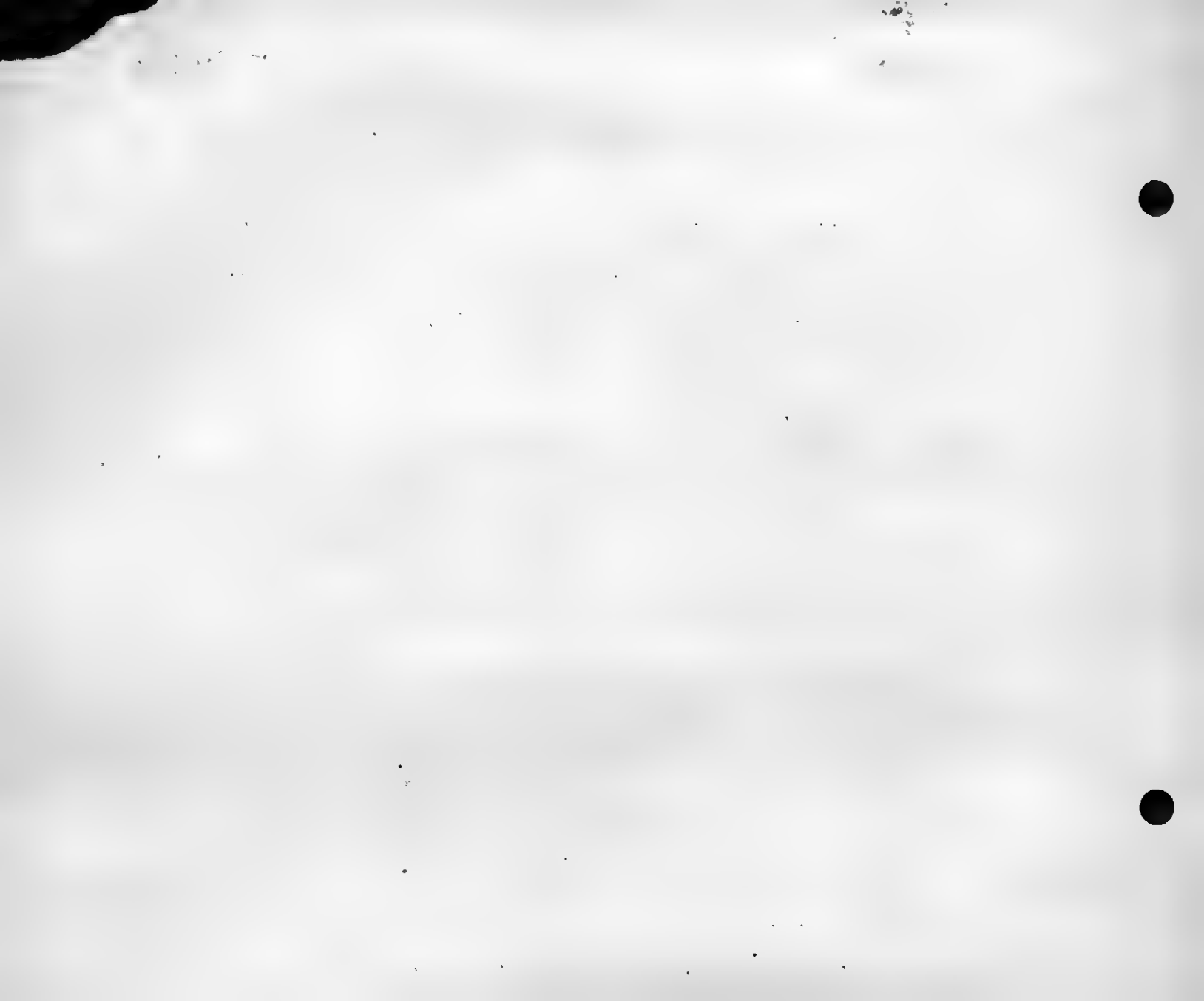
## CERTIFICATE OF DEATH

00124

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u></u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Arundel Hospital</u>		d. STREET ADDRESS <u>5629 Anthony Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Raymond</u> Middle <u>L.</u> Last <u>Jones</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>5</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-9-1900</u>
9. AGE (In years last birthday) Yrs. <u>66</u>		10. IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Martin Company</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles B. Jones</u>		14. MOTHER'S MAIDEN NAME <u>Anna Raborg</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give year or dates of service) <u>yes</u>		16. SOCIAL SECURITY NO <u>2140141444</u>	
17. INFORMANT <u>Mrs Anne Bailey</u>		Address <u>600 Everett Rd.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>coronary atherosclerosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>coronary atherosclerosis</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u> <u>37 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes Mellitus - 15 years</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>NONE</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u></u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> , to <u>1/5</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1/5/67</u> , 19 <u></u> , and that death occurred at <u>A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Stuart D. Sunday</u> M.D.		22b. DATE SIGNED <u>1/2/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>STUART D. SUNDAY</u>		22d. ADDRESS <u>201 E. 33rd St (18)</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE THEREOF <u>1-7-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 10 1967</u>	
ADDRESS <u>Baltimore, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. Ruck</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

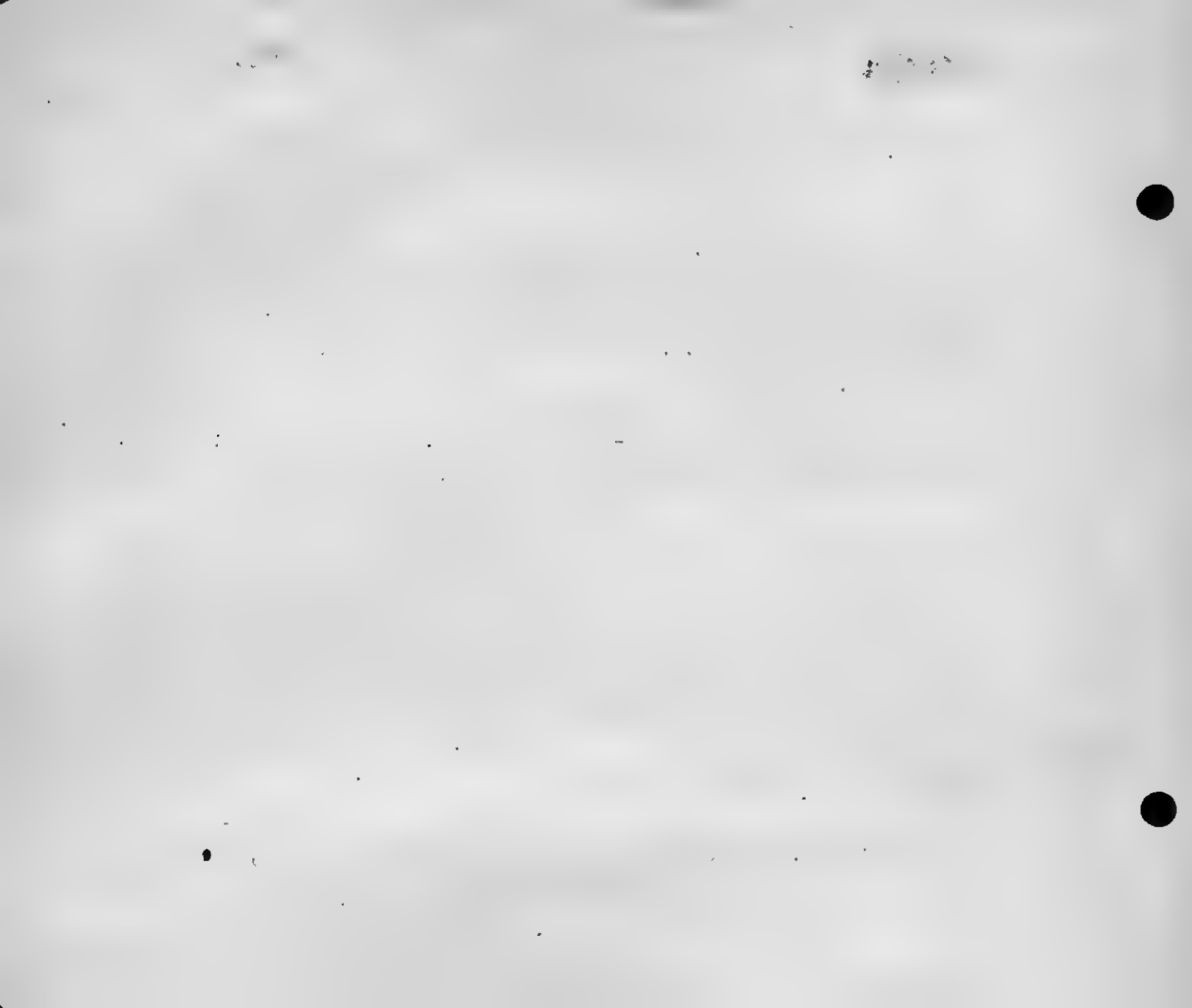
00125

00124

<b>1. PLACE OF DEATH</b> a. COUNTY <u>ANNE ARUNDEL</u> <span style="float: right;"><b>MARYLAND</b></span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FT GEO G. MEADE</u> c. LENGTH OF STAY IN b. <u>45 Min</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Kimbrough Army Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town, <u>Laurel</u> d. STREET ADDRESS <u>184 Ethel Drive, Apt 208</u> e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>BERTRAN</u> First <u>JOSEPH</u> Middle Last <b>4. DATE OF DEATH</b> <u>JANUARY 15</u> 19 <u>67</u>		<b>5. SEX</b> <u>MALE</u> <b>6. COLOR OR RACE</b> <u>CAU</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>April 1913</u>			
<b>9. AGE</b> (In years last birthday) <u>53</u> yrs. <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired serviceman</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>U.S. Air Force</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>San Francisco, Calif</u> <b>12. CITIZEN OF WHAT COUNTRY</b> <u>USA</u>		<b>13. FATHER'S NAME</b> <u>Melville M. Joseph</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Jessie Brown</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>1 Aug 66</u>		<b>16. SOCIAL SECURITY NO.</b> <u>558-10-1036</u>		<b>17. INFORMANT</b> Address <u>Alexander, Va.</u> <u>Mildred C. Joseph, 6621 Wakefield Drive</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> 40011 } DUE TO <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (b) } (c), stating the underlying cause last. } DUE TO						INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, notify medical examiner) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>19</u> e.m. p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that</b> <u>10</u> (this hospital) attended the deceased from <u>15 Jan</u> , 19 <u>67</u> , to <u>15 Jan</u> , 19 <u>67</u> , that (s) (we) last saw the deceased alive on <u>15 Jan</u> , 19 <u>67</u> , and that death occurred at <u>10</u> p.m. from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <u>Carl S. Rosen</u>		<b>22b. DATE SIGNED</b> <u>15 Jan 67</u>		<b>22c. PHYSICIAN'S NAME</b> (Type) <u>CARL S. ROSEN, CPT, MC</u>			
<b>22d. ADDRESS</b> <u>KIMBROUGH ARMY HOSP, FT GEO G MEADE, MD</u>		<b>22e. ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>1-19-67</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Arleson to National</u>			
<b>23d. LOCATION</b> (City, town or county) <u>Fort Meade, MD</u>		<b>(State)</b>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>James F. Adams</u>		<b>24b. ADDRESS</b> <u>James F. Adams, Home, Alexandria, Va.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>JAN 20 1967</u>			
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00125

CERTIFICATE OF DEATH

00126

1 PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c LENGTH OF STAY in 1b <b>1 hr. 15 min.</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>		d STREET ADDRESS <b>Tracy's Landing</b> RURAL	
3. NAME OF DECEASED (Type or print) First <b>Alice</b> Middle <b>Lillian</b> Last <b>JOYCE</b>		4 DATE OF DEATH Month <b>1</b> Day <b>6</b> Year <b>19 67</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-31-10</b>
9 AGE (in years last birthday) yrs <b>56</b>		10 IF UNDER 1 YEAR Months <b>6</b> Days <b>19</b> Hours <b>67</b> Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>VIRGINIA</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>✓ LESTER CLARK</b>		14. MOTHER'S MAIDEN NAME <b>MARY B. KARNES</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO. <b>578-18-3171</b>	
17 INFORMANT <b>R. Vernon Joyce</b>		Address <b>Tracys Landing, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Hypertension</b> DUE TO (b) <b>Coronary Heart Failure</b> DUE TO (c) <b>Rheumatic Heart Disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b> <b>mon yrs</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Jan. 6</b> , 19 <b>67</b> to <b>Jan. 6</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>Jan. 6</b> , 19 <b>67</b> , and that death occurred at <b>3:30 PM</b> , from causes and on the date stated above.			
22a SIGNATURE <b>R. Biern</b>		22b. DATE SIGNED <b>1/5/67</b>	
22c PHYSICIAN'S NAME (Type) <b>R. BIERN</b>		22d ADDRESS <b>Annapolis Md.</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b DATE THEREOF <b>1-9-67</b>	23c NAME OF CEMETERY OR CREMATORY <b>Hillcrest</b>	23d LOCATION (City or Town) (County) (State) <b>Annapolis, Md.</b>
24 FUNERAL DIRECTOR <b>JA Kordas</b>		25a REC'D BY REGISTRAR <b>JAN 18 1967</b>	
ADDRESS <b>12 Ridgely Ave, Annapolis, Md</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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20 M 1/66

00126

CERTIFICATE OF DEATH

00127

1 PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Millersville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <del>Millersville</del> <b>Odenton</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Knollwood Manor Nursing Home</b>		d. STREET ADDRESS <b>Harding St., Knollwood Manor Nursing Home</b>	
3 NAME OF DECEASED (Type or print) <b>Helen M. Kaiss</b> First Middle Last		4. DATE OF DEATH <b>January 29, 1967</b> Month Day Year	
5 SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <b>March 30, 1891</b>
9 AGE (In years last birthday) <b>75</b> yrs		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Salem, New Hampshire</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George W. Pierce</b>		14. MOTHER'S MAIDEN NAME <b>Clara A. Armour</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-54-1680</b>	
17. INFORMANT <b>Kenneth P. Daly (son)</b>		Address <b>11 King Street Cambridge, Massachusetts</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>493X</b> IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>--</b> DUE TO (c) <b>--</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis, general and cerebral</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>June 30, 1965</b> to <b>January 29, 1967</b> , that (I) (we) last saw the deceased alive on <b>January 8, 1967</b> , and that death occurred on <b>January 29, 1967</b> at <b>10:15</b> M., from causes and on the date stated above.			
22a. SIGNATURE <b>Charles W. Kinzer</b>		22b. DATE SIGNED <b>January 29, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Charles W. Kinzer, M. D.</b>		22d. ADDRESS <b>South River Medical Center Edgewater, Maryland 21037</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Jan. 30, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Epiphany Episcopal Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Odenton A.A. Md.</b>
24. FUNERAL DIRECTOR <b>Beverley E. Hopping</b> <b>Hopping Funeral Home</b>		25a. REC'D BY REGISTRAR <b>Beverley E. Hopping</b> <b>Annapolis, Md.</b>	
25b. REGISTRAR'S SIGNATURE <b>John C. Sweeney</b>		DATE <b>JAN 31 1967</b>	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00127

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00128

1 PLACE OF DEATH a COUNTY <b>Anne Arundel</b> b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Millersville</b> c LENGTH OF STAY IN b <b>Minutes</b> d NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Rt. 424 and Patuxent River.</b>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Anne Arundel</b> c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b> d STREET ADDRESS <b>103 Crain Highway</b> e RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>EDGAR A. KEMP</b>		4 DATE OF DEATH Month Day Year <b>January 22 19 67</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>18 May 1942</b>
9 AGE (In years last birthday) <b>24 yrs</b>		10 IF UNDER 1 YEAR Months Days Hours Min.	11 IF UNDER 24 HRS Months Days Hours Min.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>Arthur L. Kemp, Sr.</b>		14 MOTHER'S MAIDEN NAME <b>Alice May Trail</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>214-40-1341</b>	
17 INFORMANT <b>Mrs. Connie Kemp, same as 2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY. <b>919.8 IMMEDIATE CAUSE (a) Gunshot Wound of Chest.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Accidental discharge of rifle while target shooting.</b>			
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Interval BETWEEN ONSET AND DEATH	
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Accidental discharge of rifle while target shooting.</b>	
20c TIME OF INJURY Month Day Year <b>1/22 1967</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office, etc.) <b>Field</b>		20f (City or town) (County) (State) <b>A.A. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles S. Petty</b> EXAMINER'S NAME (Type) <b>Charles S. Petty</b>		22. DATE SIGNED <b>1/23/67</b>	
23a B. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>25 Jan. 1967</b>	
23c NAME OF CEMETERY OR CREMATORY <b>Glen Haven Memorial</b>		23d LOCATION (City or town) (County) (State) <b>Glen Burnie, Md.</b>	
24 FUNERAL DIRECTOR <b>Kirkley Funeral Home, Glen Burnie, Md.</b>		25a REC'D BY REGISTRAR DATE <b>JAN 26 1967</b>	
25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
00128					00129									
1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Ft G.G. Meade, Maryland</b> c. LENGTH OF STAY IN b <b>DOA</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Kimbrough Army Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Ft Geo G. Meade, Maryland</b> d. STREET ADDRESS <b>1858-E Patton Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <b>Marika Levette King</b>					4. DATE OF DEATH Month <b>January</b> Day <b>1</b> Year <b>1967</b>									
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>21 October 1966</b>		9. AGE (In years last birthday) <b>2 mo.</b> yrs						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Ft Geo G. Meade, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>								
13. FATHER'S NAME <b>Hebert King</b>					14. MOTHER'S MAIDEN NAME <b>Odessa L. Drake</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>					16. SOCIAL SECURITY NO. <b>None</b>					17. INFORMANT <b>1858-E Patton Dr</b> <b>Hebert King(F) Ft G.G. Meade, Maryland</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Crib Death (Pending Autopsy) /</b> <b>773.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) DUE TO (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)														
21. I certify that <del>it</del> (this hospital) attended the deceased <del>xxx</del> at <b>1025, 1 Jan 1967</b> and the <del>xxx</del> , <del>xxx</del> , <del>xxx</del> <del>xxx</del> deceased <del>xxx</del> was <b>DOA at 1005AM</b> , <del>xxx</del> from the causes and on the date stated above.														
22a. SIGNATURE <b>BURTON A. JOHNSON, CPT MC</b>					22b. DATE SIGNED <b>1 Jan 67</b>									
22c. PHYSICIAN'S NAME (Type) <b>BURTON A. JOHNSON, CPT, MC</b>					22d. ADDRESS <b>Kimbrough AH FT GEO G. MEADE, MD</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>Jan. 9, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL CE.</b>		23d. LOCATION (City, town or county) (State) <b>ARLINGTON, VIRGINIA</b>								
24. FUNERAL DIRECTOR'S SIGNATURE <b>David S. Waddy, Samuel, Md</b>					25a. REC'D BY REGISTRAR <b>DATE JAN 25 1967</b>					25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>				



00129

## CERTIFICATE OF DEATH

00130

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>		c. LENGTH OF STAY IN 1b <b>11</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>North Arundel Hospital</b>		d. STREET ADDRESS <b>Box 4 Chesapeake Trailer Court</b>	
3. NAME OF DECEASED (Type or print) <b>OLLIE</b>		4. DATE OF DEATH Month <b>January</b> Day <b>10</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12 Dec. 1888</b>
9. AGE (In years last birthday) <b>78</b> yrs		IF UNDER 1 YEAR Months <b>10</b> Days <b>19</b> Hours <b>67</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>(ret) Electrician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Local Union 24</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Ill.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Chris King</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth (Unknown)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>216-10-0628</b>	
17. INFORMANT <b>Marie H. King - Same as # 2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO <b>Arteriosclerotic heart disease</b> (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1955</b> to <b>Jan 10</b> , 1967, that (I) (we) last saw the deceased alive on <b>Dec 21</b> , 1966, and that death occurred at <b>4:00 A.M.</b> , from causes and on the date stated above			
22a. SIGNATURE <b>Joseph Taler</b>		22b. DATE SIGNED <b>1/11/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOSEPH TALER</b>		22d. ADDRESS <b>45 Sprucehurst Rd. Glen Burnie, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/13/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Memorial Pk.</b>		23d. LOCATION (City or Town) (County) (State) <b>Glen Burnie, Md.</b>	
24. FUNERAL DIRECTOR <b>Robert Pulace</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>JAN 13 1967</b>	



00130

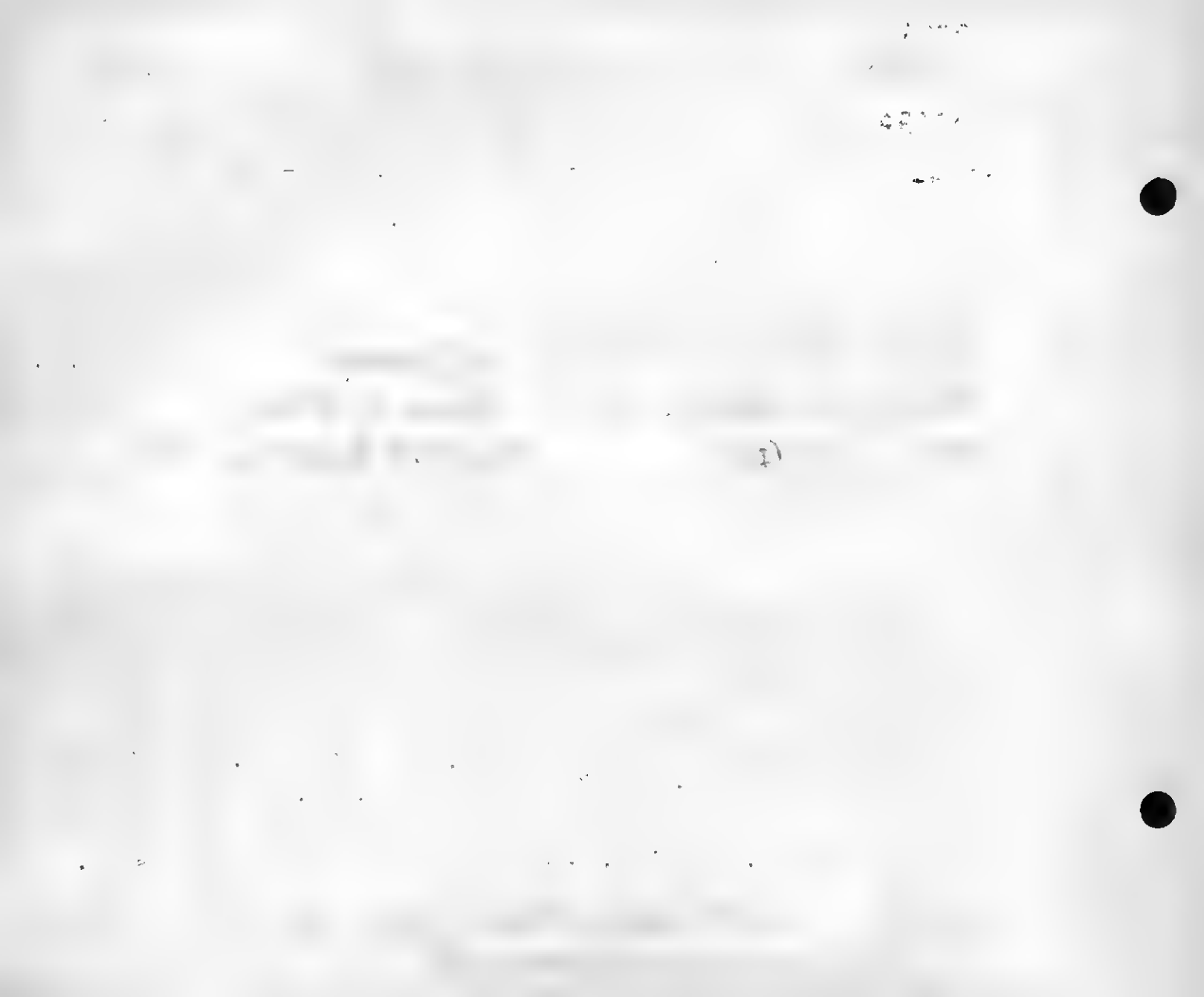
## CERTIFICATE OF DEATH

00131

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>3 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>		d. STREET ADDRESS <b>Rt. 3, Box 759B</b>	
3. NAME OF DECEASED (Type or print) <b>William Andrew KNOBLOCK</b>		4. DATE OF DEATH Month <b>January</b> Day <b>27</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 2, 1896</b>
9. AGE (In years last birthday) <b>70 yrs</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Mins <b>0</b>	
10a. U.S. AL. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RET CITY GOVNT.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>GOVNT</b>	
11. BIRTHPLACE (County & State or foreign country) <b>N. CANAAN, New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>BALTICE KNOBLOCK</b>		14. MOTHER'S MAIDEN NAME <b>ANNA F. FREY</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <b>YES WW II</b>		16. SOCIAL SECURITY NO. <b>HELEN B. KNOBLOCK #2</b>	
17. INFORMANT <b>HELEN B. KNOBLOCK #2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO <b>Ischemic &amp; Reperfusion Arteriosclerosis</b> DUE TO <b>Acute Aneurysm</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>1:10 A.M. Jan 27 1967</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <b>Jan. 24, 1967</b> to <b>Jan. 27, 1967</b> , that (I) (we) last saw the deceased alive on <b>Jan. 27, 1967</b> , and that death occurred at <b>1:10 A.M.</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Stephen B. Hiltabidle</b>		22b. DATE SIGNED <b>1/27/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Stephen B. Hiltabidle, M.D.</b>		22d. ADDRESS <b>121 Cathedral St., Annapolis, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>1-29-1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>MAIN STREET CEM.</b>		23d. LOCATION (City or Town) (County) (State) <b>DALTON MASS.</b>	
24. FUNERAL DIRECTOR <b>JOHN M. TAYLOR-SOWS</b>		25a. REC'D BY REGISTRAR <b>JAN 30 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles J. J.</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

00131

CERTIFICATE OF DEATH

00132

1. PLACE OF DEATH a. COUNTY <u>A.A.Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SEVERNA PARK</u>		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>RIVERDALE RD.</u>		d. STREET ADDRESS <u>ST. MARGARETS</u>	
3. NAME OF DECEASED (Type or print) <u>ROSA VIRGINIA KNOWLES</u>		4. DATE OF DEATH Month <u>1</u> Day <u>16</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-20-1886</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	9. AGE (In years last birthday) <u>80</u> yrs
11. BIRTHPLACE (County & State, or foreign country) <u>ST. MARGARETS, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>UNK</u>		14. MOTHER'S MAIDEN NAME <u>UNK</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Lillian M. Prager</u>		Address <u>#2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> DUE TO (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>Asthma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		INTERVAL BETWEEN ONSET AND DEATH <u>4 HRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1958</u> , to <u>Jan</u> , 1967, that (I) (we) last saw the deceased alive on <u>Jan 15</u> , 1967, and that death occurred at <u>8A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Francis I. Codd</u>		22b. DATE SIGNED <u>1-16-67</u>	22c. PHYSICIAN'S NAME (Type) <u>Francis I. Codd M.D.</u>
22d. ADDRESS <u>Severna Park, Md.</u>		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22f. REC'D BY REGISTRAR <u>Charles Judge</u>		22g. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-18-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR Bluff</u>
23d. LOCATION (City or Town) (County) (State) <u>ANNAPOLIS A.A. MD.</u>		23e. REC'D BY REGISTRAR <u>Jan 13 1967</u>	



## CERTIFICATE OF DEATH

00132

00133

1 PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>Annapolis</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>		d. STREET ADDRESS <b>38 Pinkney St.</b>	
3. NAME OF DECEASED (Type or print) <b>Thomas NMN KYLER</b>		4. DATE OF DEATH Month <b>January</b> Day <b>19</b> Year <b>1967</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 5, 1906</b>
9. AGE (In years last birthday) <b>60</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plumbers Helper</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Thomas Kyler</b>		14. MOTHER'S MAIDEN NAME <b>Airy Crampton</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-05-1006</b>	
17. INFORMANT <b>Florence Green</b>		Address <b>817 Spa Rd, Anne, Md</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DISEASE CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO (b) <b>Coronary artery Disease</b> DUE TO (c) <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o m p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1-13-67</b> , 19 <b>67</b> , to <b>1-19</b> , 19 <b>67</b> , that (I) (we) lost saw the deceased alive on <b>1-14-67</b> , 19 <b>67</b> , and that death occurred at <b>10:50 P.M.</b> M. from causes and on the date stated above.			
22a. SIGNATURE <b>A. T. Allen</b>		22b. DATE SIGNED <b>1-22-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>A T ALLEN</b>		22d. ADDRESS <b>62 Cathedral St</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>1-24-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Brewer Hill</b>	23d. LOCATION (City or Town) (County) (State) <b>Annapolis A.A.Co Md</b>
24. FUNERAL DIRECTOR <b>C.E. Hicks, 111</b>		25a. REC'D BY REGISTRAR <b>JAN 27 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

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25. 25

00133

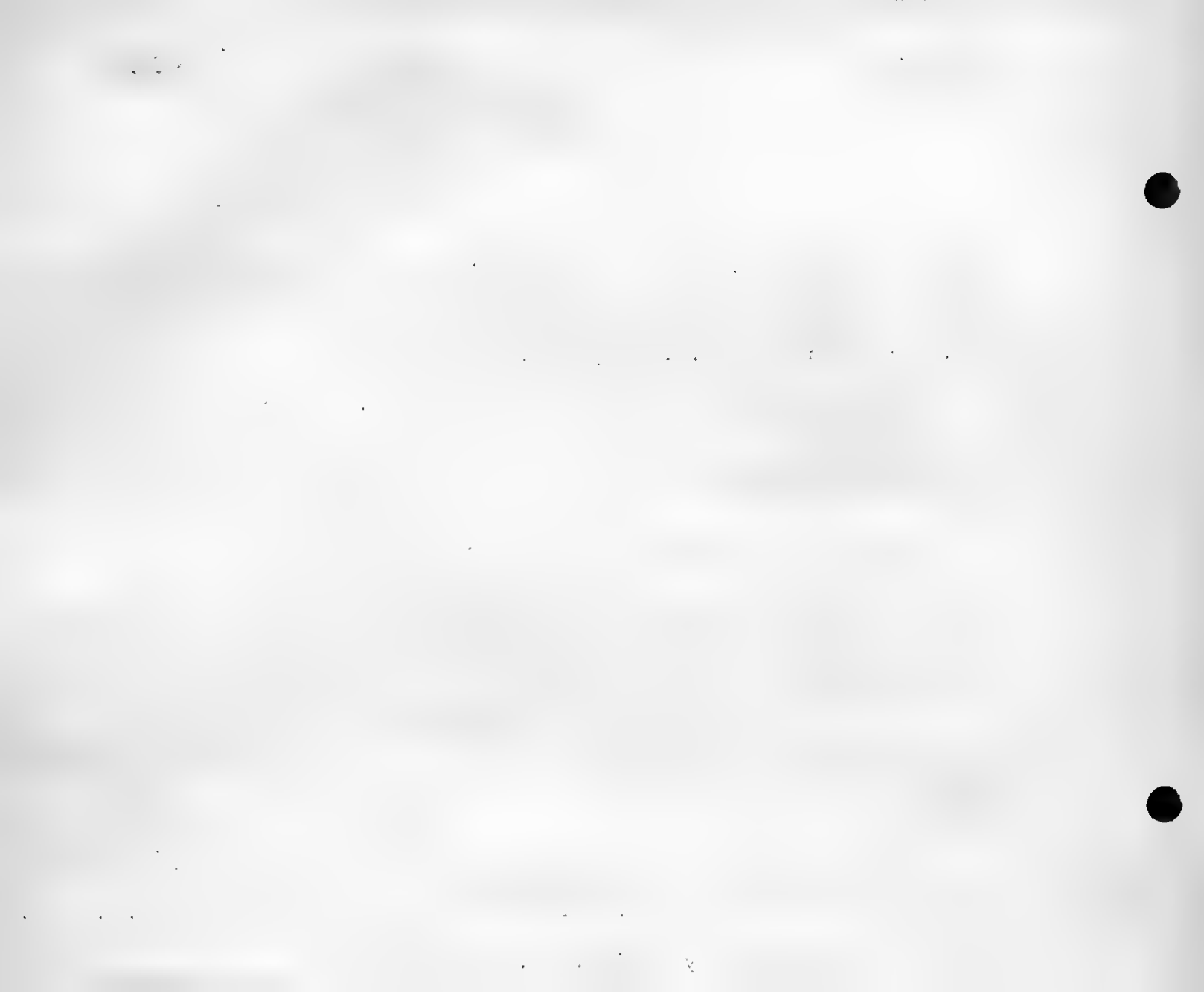
## CERTIFICATE OF DEATH

00133

1 PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c LENGTH OF STAY IN TB <b>1/2 hour</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hosp.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>Robert Irving Lansdown Sr.</b>		4 DATE OF DEATH <b>January 22 1967</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>Cauc.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH <b>30 May 1887</b>
9. AGE (in years lost birthday) <b>79</b> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of preceding life, even if retired) <b>Ret. Truck Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Navy Dept.</b>	
11. BIRTHPLACE (County & State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Alexander Lansdown</b>		14. MOTHER'S MAIDEN NAME <b>Carrie M. Porter</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Ruth Wiltshire (daughter)</b>		Address <b>same address</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction (suspected)</b> 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis, general &amp; coronary</b> DUE TO (c) <b>many years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1/2 hour</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary emphysema, Urinary tract infection</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10 June, 1966</b> , to <b>22 Jan., 1967</b> , that (I) (we) last saw the deceased alive on <b>3 Jan., 1967</b> , and that death occurred at <b>4:42 M</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>Charles W. Kinzer</i>		22b. DATE SIGNED <b>22 Jan. 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Charles W. Kinzer, M. D.</b>		22d. ADDRESS <b>South River Medical Bldg. Edgewater, Maryland 21037</b>	
23a. BURIAL, CREMATION, OR OTHER (Specify)		23b. DATE THEREOF <b>1/25/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>		23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor P.G. Md.</b>	
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR <b>JAN 26 1967</b>	
25b. REGISTRAR'S SIGNATURE <i>Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00134

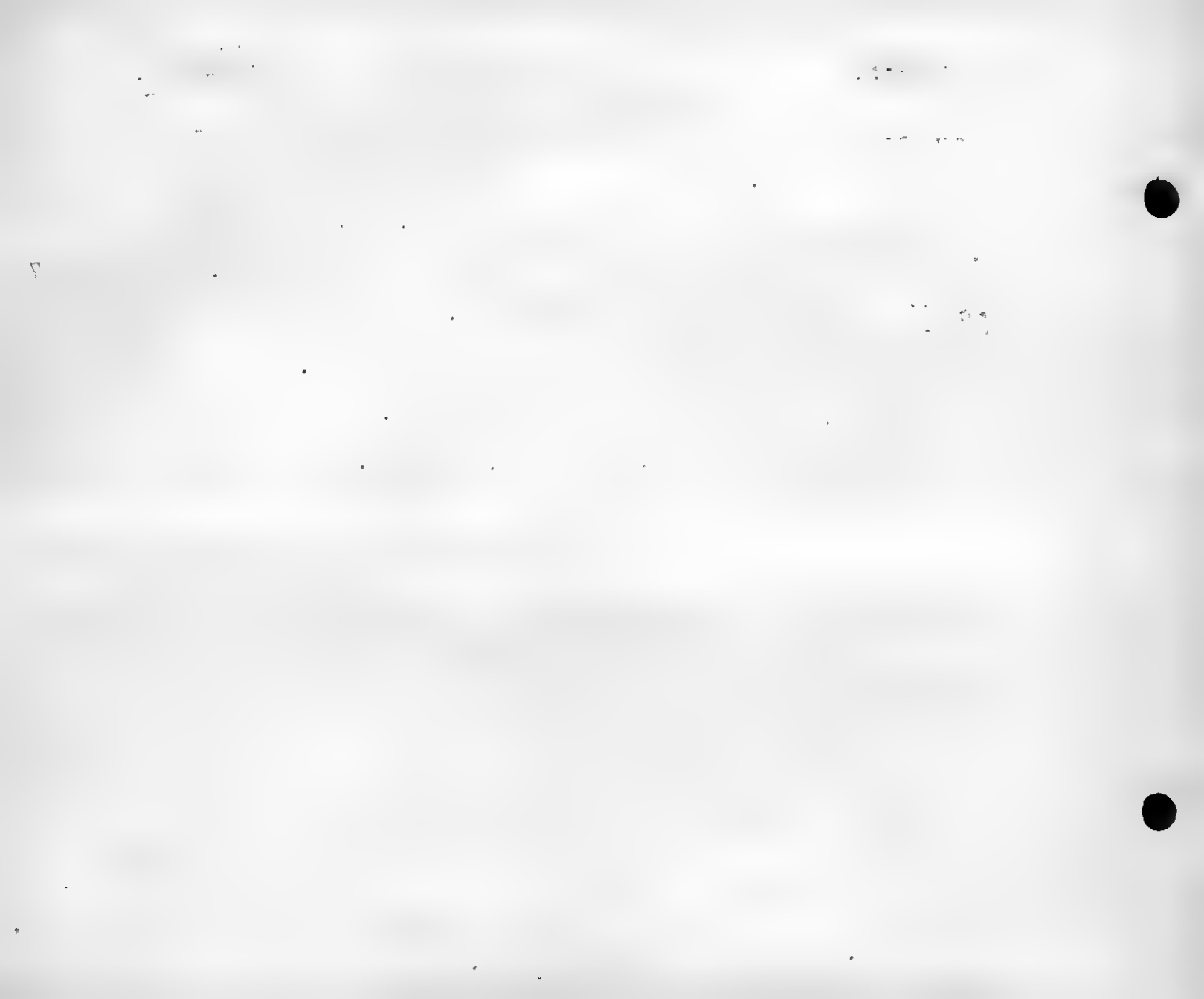
## CERTIFICATE OF DEATH

00135

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Millersville, Md.</b>				c. LENGTH OF STAY IN lb <b>Edgewater</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Knollwood Nursing Home</b>				d. STREET ADDRESS <b>Rt 2 Box 200</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Nora Beard Lawson</b>				4. DATE OF DEATH Month Day Year <b>Jan. 15 19 67</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 1884</b>	9. AGE (In years last birthday) <b>82</b> yrs	10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>house wife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Rockbridge, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>William B. Beard</b>				14. MOTHER'S MAIDEN NAME <b>Julia F. Clark</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>231-60-2235A</b>		17. INFORMANT Address <b>Mrs. Frances L. Woolwine - same as #2 above</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Conjunctive heart failure</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>Anemia</b>							INTERVAL BETWEEN ONSET AND DEATH <b>several months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Chronic cystitis &amp; pyelonephritis</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.							
22a. SIGNATURE <b>Bm Smith</b>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b>Jan 15, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>RAY M. SMITH M.D.</b>				22d. ADDRESS <b>SEVERNA PARK, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/15/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Presbyterian Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Lynchburg Campbell Va.</b>	
24. FUNERAL DIRECTOR'S <b>Beverly E. Hopping</b> HOPPING FUNERAL HOME				25a. REC'D BY REGISTRAR <b>Annopolis, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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00135

CERTIFICATE OF DEATH

00136

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Baltimore</b> c. LENGTH OF STAY IN 1b <b>25 years</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>211 Audrey Ave.</b>		d. STREET ADDRESS <b>211 Audrey Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>ALBIN</b> Middle <b>NMN</b> Last <b>LECHOWICZ</b>		4. DATE OF DEATH Month <b>January</b> Day <b>24</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan 19, 1893</b>
9. AGE (In years last birthday) <b>74</b> yrs		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>14</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Iron Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ship Building</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Carl Lechowicz</b>		14. MOTHER'S MAIDEN NAME <b>Pauline ----</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-05-7407</b>	
17. INFORMANT <b>Mrs. Albin Lechowicz</b>		Address <b>(same)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> DUE TO <b>H. S. C. V. D.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 11</b> , 19 <b>62</b> , to <b>Jan 24</b> , 19 <b>67</b> , that (II) (we) last saw the deceased alive on <b>Jan. 24</b> , 19 <b>67</b> , and that death occurred at <b>7:45 A.M.</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Robert W. Dabolin</b>		22b. DATE SIGNED <b>Jan. 24, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Robert Dabolin</b>		22d. ADDRESS <b>400 Grain Highway, N.W., Glen Burnie</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan. 27, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Holy Cross Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Ritchie Hwy., A.A.Co., Md.</b>	
24. FUNERAL DIRECTOR <b>George J. Gonce-4001 Ritchie Hgwy., Baltimore</b>		25a. REC'D BY REGISTRAR <b>JAN 31 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>John J. Judge</b>			



00136

## CERTIFICATE OF DEATH

00137

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) o STATE <b>Maryland</b> b. COUNTY <input checked="" type="checkbox"/>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN 15 <b>11 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Crownsville State Hospital</b>		d. STREET ADDRESS <b>2502 E. Jefferson St.</b>	
3. NAME OF DECEASED (Type or print) <b>#34194 Calvert George Litz</b>		4. DATE OF DEATH Month <b>1</b> Day <b>10</b> Year <b>67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/9/16</b>
9. AGE (In years last birthday) yrs <b>50</b>		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>10</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labore</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Frank Litz</b>		14. MOTHER'S MAIDEN NAME <b>Wolfe</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO <b>216-01-8467</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic Failure</b> DUE TO (b) <b>Cirrhosis of Liver</b> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LOST. (c) <b>Chronic Alcoholism</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>-----</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <b>-----</b>	20f. (City or town) (County) (State) <b>-----</b>
21. I certify that (I) (this hospital) attended the deceased from <b>12/30/1966</b> , to <b>1/10/1967</b> , that (I) (we) last saw the deceased alive on <b>1/10/1967</b> , and that death occurred at <b>2:AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Benedict</b>		22b. DATE SIGNED <b>1/10/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. Benedict, M.D.</b>		22d. ADDRESS <b>Crownsville State Hospital</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>1-13-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>BALTO. NATIONAL Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>BALTO., Md.</b>
24. FUNERAL DIRECTOR <b>Jefferson - 2334 Jefferson St.</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 12 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or reinterment and in any event, within 72 hours after death.



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

00137

00138

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Margarets</u> c. LENGTH OF STAY IN <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bay Manor Nursing Home</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis,</u> d. STREET ADDRESS <u>207 Ridgely Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <u>James</u> <u>John</u> <u>Lorens</u> 5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>August 9, 1875</u> 9. AGE (In years last birthday) <u>91</u> yrs. IF UNDER 1 YEAR: Months <u>23</u> Days <u>19</u> IF UNDER 24 HRS. Hours <u>67</u> Min.				<b>4. DATE OF DEATH</b> <u>January 23, 1967</u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>blacksmith</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Boundry</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Germany</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>James Lorens</u> 14. MOTHER'S MAIDEN NAME <u>unknown</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u> 16. SOCIAL SECURITY NO. <u>219-16-1475</u> 17. INFORMANT <u>Mrs. Lillian Darden same as #2 above</u> Address _____					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO <u>Cerebral Vascular insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) _____								INTERVAL BETWEEN ONSET AND DEATH <u>4 to 5 days</u> <u>Unknown</u>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18) OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY: Hour <u>19</u> e.m. Month, Day, Year <u>1/20/1967</u> 20d. INJURY OCCURRED: While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____									
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>8/2</u> <u>1965</u> <b>to</b> <u>1/23</u> <u>1967</u> <b>that (I) (we) last saw the deceased alive on</b> <u>1/20</u> <u>1967</u> <b>and that death occurred</b> <u>8:30 PM</u> <b>from the causes and on the date stated above.</b> 22a. SIGNATURE <u>Richard I. Hochman, MD</u> 22b. DATE SIGNED <u>1/23/67</u> 22c. PHYSICIAN'S NAME (Type) <u>Richard I. Hochman, MD</u> 22d. ADDRESS <u>59 Franklin St, Annapolis, Md</u> 22e. MED. DIRECTOR <input type="checkbox"/> 22f. STAFF PHYS. <input type="checkbox"/>									
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u> <b>23b. DATE THEREOF</b> <u>Jan. 25, 1967</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Bohemian National Cem.</u> <b>23d. LOCATION (City, town or county)</b> <u>Baltimore City</u> <b>(State)</b> <u>Maryland</u>									
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Beverley E. Hopping</u> <b>25a. REC'D BY REGISTRAR</b> <u>Charles Judge</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u> <u>Hopping Funeral Home</u> <u>Annapolis, Md.</u> <b>DATE</b> <u>JAN 26 1967</u>									



00138

## CERTIFICATE OF DEATH

00139

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b>	
b. CITY OR TOWN (If outside corporate limits, write R-RAL and give nearest town) <b>RURAL-GLEN BURNIE</b>		c. LENGTH OF STAY IN 1b <b>2 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>NORTH ARUNDEL HOSPITAL</b>		d. STREET ADDRESS <b>318 SNOW HILL ROAD</b>	
3. NAME OF DECEASED (Type or print) First <b>MALACHI</b> Middle Last <b>LOVE</b>		4. DATE OF DEATH Month <b>JANUARY</b> Day <b>25</b> Year <b>1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JANUARY 1, 1903</b>
9. AGE (In years last birthday) <b>64</b> yrs		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>supervisor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>cementary</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>NEW PORT NEWS, VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Love</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Holloman</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>Alanna Love</b>	
17. INFORMANT <b>Alanna Love</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4XU-1</b> DUE TO <b>Cardiac Arrest</b> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CAARDIAC DECOMPESTATION</b> DUE TO (c) <b>ACUTE-ANTERO LATERAL MYOCARDIAL INFARCT</b> 20=		INTERVAL BETWEEN ONSET AND DEATH <b>1 H.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>HYPERTENSION - DIABETIS MELLITUS -</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 23, 1967</b> to <b>Jan 25, 1967</b> that (I) (we) last saw the deceased alive on <b>Jan 25, 1967</b> , and that death occurred at <b>10:05 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Dr. Carlos E. Arrabal</b>		22b. DATE SIGNED <b>Jan 25-1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>CARLOS E ARRABAL</b>		22d. ADDRESS <b>2705 MOUNTAIN RD- PASADENA 91122</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan 29/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Cem</b>		23d. LOCATION (City or town) (County) (State) <b>A. A. County, Md</b>	
24. FUNERAL DIRECTOR <b>Yonah, Elickson</b>		25a. REC'D BY REGISTRAR <b>11297. Cuckins</b>	
25b. REGISTRAR'S SIGNATURE <b>Jan 30 1967</b>		DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00139

CERTIFICATE OF DEATH

00140

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>	
c. LENGTH OF STAY IN 1b <b>4 days</b>		d. STREET ADDRESS <b>Barbud Lane</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Helen</b> Middle <b>June</b> Last <b>LUTTRELL</b>		4. DATE OF DEATH Month <b>January</b> Day <b>20</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 20, 1916</b>
9. AGE (In years last birthday) <b>50 yrs</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>HARRY HUNZIKER</b>		14. MOTHER'S MAIDEN NAME <b>EVA B. HARRISON</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>RICHARD E. LUTTRELL SR #2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Cervix c</b> DUE TO <b>Metastasis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Metastasis</b> (c) <b>Metastasis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>8 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>0</b> m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) <b>(do not know)</b> attended the deceased from <b>1967</b> , to <b>Jan. 20, 1967</b> , that (I) <b>(do not know)</b> saw the deceased alive on <b>1-20</b> 19 <b>67</b> , and that death occurred at <b>6:45 pm</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>E. Schubert</b>		22b. DATE SIGNED <b>1/20/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>E. Schubert</b>		22d. ADDRESS <b>Annapolis Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>1-24-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>SHERWOOD CEM.</b>	23d. LOCATION (City or Town) (County) (State) <b>SHERWOOD MD.</b>
24. FUNERAL DIRECTOR <b>JOHN M. TAYLOR SON ANNAPOLIS MD</b>		25a. REC'D BY REGISTRAR <b>DATE JAN 24 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>John M. Taylor</b>			



00140

## CERTIFICATE OF DEATH

00141

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b> c. LENGTH OF STAY IN 1b <b>18yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>#113 Kent Road (Glen Gardens)</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b> d. STREET ADDRESS <b>#113 Kent Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>HECTOR (nmi) Mac Donald</b>		4. DATE OF DEATH Month <b>January</b> Day <b>4</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 19, 1905</b>
9. AGE (In years last birthday) <b>61</b> yrs		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>19</b> Hours <b>67</b> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Sydney, Nova Scotia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John J. Mac Donald</b>		14. MOTHER'S MAIDEN NAME <b>Margaret C. Mc Allister</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no none</b>		16. SOCIAL SECURITY NO. <b>168-09-1365</b>	
17. INFORMANT <b>Mrs. Nellie M. Mac Donald (wife)</b>		Address <b>#2 Same as</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>430.1</b> DUE TO <b>Craniocerebral trauma</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH <b>4</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 31, 1953</b> , to <b>Sept 4, 1967</b> , that (I) (we) lost saw the deceased alive on <b>Sept 30, 1966</b> , and that death occurred at <b>5:30 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>C. R. Mac Donald M.D.</b>		22b. DATE SIGNED <b>11/6/1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>C. R. Mac Donald M.D.</b>		22d. ADDRESS <b>204 Craia Hwy S.W. Glen Burnie</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Jan. 7, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Wheaton, Maryland</b>
24. FUNERAL DIRECTOR <b>Richard V. Singleton</b>		25a. REC'D BY REGISTRAR <b>JAN 9 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

00143

00142

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>ODENTON</b> c. LENGTH OF STAY IN b <b>DOA</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>1592 ANNAPOLIS ROAD</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>WEST VIRGINIA</b> b. COUNTY <b>MARSHALL</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>MOUNDSVILLE</b> d. STREET ADDRESS <b>1002 LAFAYETTE AVE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>OLIVER C. J. MAGERS</b>		4. DATE OF DEATH Month <b>JANUARY</b> Day <b>21</b> Year <b>1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>CAU</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3 DECEMBER 1929</b>
9. AGE (In years last birthday) <b>37</b> yrs.		IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> IF UNDER 24 HRS.: Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SOLDIER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>US ARMY</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>MOUNDSVILLE, W. VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>THOMAS J. MAGERS</b>		14. MOTHER'S MAIDEN NAME <b>ANNA ELIZABETH (MAIDEN NAME UNKNOWN)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>YES 11 YRS 4 MO</b>		16. SOCIAL SECURITY NO. <b>232-36-2080</b>	
17. INFORMANT <b>ANNA ELIZABETH MAGERS(M) MOUNDSVILLE W. VA.</b>		Address <b>1002 LAFAYETTE AVE</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>EPIDURAL HEMATOMA</b> <b>136.9</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>SECONDARY TO TRAUMA</b> (c), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CIRCUMSTANCES UNKNOWN</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 HOURS</b>
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>CIRCUMSTANCES UNKNOWN</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>0</b> a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <b>THEODORE F. TOULAN</b> attended the deceased <b>WAS DOG</b> <b>11:45</b> <b>21 Jan.</b> <b>1967</b> , and that death occurred at <b>11:45</b> AM, from the causes and on the date stated above.			
22a. SIGNATURE <b>THEODORE F. TOULAN, CPT, MC</b>		22b. DATE <b>21 JANUARY 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>THEODORE F. TOULAN, CPT, MC</b>		22d. ADDRESS <b>KIMBROUGH ARMY HOSPITAL FT GEO G. MEADE, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>Jan. 26, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>River View Cemetery,</b>	23d. LOCATION (City, town or county) (State) <b>Moundsville, West Virginia</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Harold S. Wade, 550 Wash. Blvd., Laurel, Maryland</b>		25a. REC'D BY REGISTRAR <b>JAN 25 1967</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. It may delay s necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00142

00143

1. PLACE OF DEATH a. COUNTY <b>B. A. Co.</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>91st BURNIE.</b>		2. USUAL RESIDENCE (Where deceased lived) a. STATE <b>MD</b> b. COUNTY <b>11</b>	
c. LENGTH OF STAY N 1b <b>91st BURNIE.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brooklyn Park - Bldg 25</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>NORTH ARUNDEL Hospital</b>		d. STREET ADDRESS <b>4100 Belgrave Road</b>	
3. NAME OF DECEASED (Type or print) First <b>ALTA</b> Middle <b>Z</b> Last <b>MANN</b>		4. DATE OF DEATH Month <b>1</b> Day <b>21</b> Year <b>1967</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-14-26</b>
9. AGE (In years lost birthday) <b>80 yrs</b>		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Ma</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Daniel Pfeltz</b>		14. MOTHER'S MAIDEN NAME <b>Anna Rhodes</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Family</b>		Address <b>Same</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Chronic myocardial infarction - acute</b> 4001 DUE TO <b>Myocardial infarction - chronic</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <b>Coronary atherosclerosis</b> (b) <b>Coronary atherosclerosis</b> (c) <b>Coronary atherosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>15 hours.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fracture left femur.</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Fell at home</b>	
20c. TIME OF INJURY Month Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	20f. (City or town) (County) (State) <b>Brooklyn Park MD</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>E. L. H. H.</b>		22. DATE SIGNED <b>1-21-67</b>	
EXAMINER'S NAME (Type) <b>E. L. H. H.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>1/25/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>	23d. LOCATION (City or Town) (County) (State) <b>AA Co MD</b>
24. FUNERAL DIRECTOR <b>McCully F H 237 Patapsco Ave 21225</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 24 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

1944

00143

## CERTIFICATE OF DEATH

00145

1. PLACE OF DEATH a. COUNTY <b>Alberxx Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>North Arundel Hospital</b>		d. STREET ADDRESS <b>#10 "D" Street S/W</b>	
3. NAME OF DECEASED (Type or print) First <b>ALBERT</b> Middle <b>GEORGE</b> Last <b>MARINER JR.</b>		4. DATE OF DEATH Month <b>Jan</b> Day <b>16</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 21, 1911</b>
9. AGE (In years last birthday) <b>55 yrs</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supervisor</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Albert G. Mariner</b>		14. MOTHER'S MAIDEN NAME <b>Martha Wolf</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>215/03/7179</b>	
17. INFORMANT <b>Mrs. Doris R. Mariner</b>		Address <b>Same as # 2</b>	
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarct</b> <b>420.0</b> DUE TO (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <b>9-12 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>July</b> , 19 <b>66</b> , to <b>Jan</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>Jan 10</b> , 19 <b>67</b> , and that death occurred at <b>6 A.</b> M., from causes and on the date stated above.			
22a. SIGNATURE <b>A. T. O. H. E.</b>		22b. DATE SIGNED <b>1-17-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. T. O. H. E.</b>		22d. ADDRESS <b>5 Central Ave., Glen Burnie, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Jan. 19, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Pikesville Md.</b>
24. FUNERAL DIRECTOR <b>R. V. SINGLETON</b>		25a. REC'D BY REGISTRAR <b>JAN 19 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00144

CERTIFICATE OF DEATH

00146

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>		d. STREET ADDRESS <b>4 Severn Drive</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Martha Ann MAY</b>		4. DATE OF DEATH Month Day Year <b>January 5 1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 21, 1925</b>
9. AGE (In years lost birthday) yrs. <b>41</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>5 19 67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SUPERVISOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RETAIL STORE</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>WHEELING WEST VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>THOMAS Butterworth</b>		14. MOTHER'S MAIDEN NAME <b>CHARA Scott</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>Hospital</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bronchogenic carcinoma</b> DUE TO (c) <b>—</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>7-21, 1966</b> , to <b>1-5-1967</b> , that (I) (we) last saw the deceased alive on <b>1-4-1967</b> and that death occurred at <b>1:55 A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Barber C. Palmer</b>		22b. DATE SIGNED <b>1/5/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Barber C. Palmer, M.D.</b>		22d. ADDRESS <b>121 Cathedral St., Annapolis, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>1-9-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l.</b>	23d. LOCATION (City or Town) (County) (State) <b>Arlington Va.</b>
24. FUNERAL DIRECTOR <b>John M. Lytle</b>		25a. REC'D BY REGISTRAR <b>—</b>	
25b. REGISTRAR'S SIGNATURE <b>John M. Lytle</b>		DATE <b>JAN 10 1967</b>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00145

CERTIFICATE OF DEATH

00147

1 PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b> c. LENGTH OF STAY IN (b) <b>4 years</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Crownsville State Hospital</b>		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>1</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>316 Zeppelin Ave</b> d. STREET ADDRESS <b>Baltimore</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>#24760 Arich, McClain</b>		4 DATE OF DEATH Month Day Year <b>1 23 19 67</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>Negro</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Sep. DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>--1920</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Constructionist</b>		9b. KIND OF BUSINESS OR INDUSTRY <b>North Carolina</b>	9c. AGE (In years lost birthday) <b>47 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Constructionist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>North Carolina</b>	10c. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13 FATHER'S NAME <b>Dan McClain</b>		14 MOTHER'S MAIDEN NAME <b>Zelma Lewis</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>?</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Epilepsy - Torula Encephalitis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1/28/1963</b> to <b>1/23/1967</b> that (I) (we) last saw the deceased alive on <b>1/23/1967</b> , and that death occurred at <b>1:30</b> M, from causes and on the date stated above.			
22a SIGNATURE <b>Hildagard Heard Reissman</b>		22b. DATE SIGNED <b>1/23/67</b>	
22c PHYSICIAN'S NAME (Type) <b>Hildagard Heard Reissman, M.D.</b>		22d. ADDRESS <b>Crownsville State Hospital Md.</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b DATE THEREOF <b>1/24/67</b>	23c NAME OF CEMETERY OR CREMATORY <b>Whiteville - N.C.</b>	23d. LOCATION (City or Town) (County) (State) <b>WHITEVILLE - N.C.</b>
24. FUNERAL DIRECTOR <b>Maxine Palmer 638 N. Commercial St</b>		25a REC'D BY REGISTRAR <b>JAN 24 1967</b>	25b REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

00144

1 PLACE OF DEATH a. COUNTY <i>AA Co</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>AA Co</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Arnold</i>		c. LENGTH OF STAY IN 1b <i>Arnold, MD</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS <i>Middleway Rd</i>	
3 NAME OF DECEASED (Type or print) <i>Jessie G McGRAW</i>		4. DATE OF DEATH Month <i>Jan</i> Day <i>15</i> Year <i>1967</i>	
5 SEX <i>Female</i>	6 COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <i>Oct 31, 1892</i>
9 AGE (In years lost birthday) yrs <i>74</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>—</i>	
10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Easton MD</i>	
12 CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>George R. Jones</i>	
14. MOTHER'S MAIDEN NAME <i>Emma P. Wales</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>—</i> (If yes give war or dates of service)	
16 SOCIAL SECURITY NO. <i>220-48-7506</i>		17 INFORMANT <i>BARBARA SANDERS</i> Address <i>Arnold, MD</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY <i>332X</i> IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> DUE TO (b) <i>Cerebral Arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <i>—</i>			INTERVAL BETWEEN ONSET AND DEATH <i>few hours</i>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <i>19</i> to <i>19</i> , that (I) (we) last saw the deceased alive on <i>10/30/67</i> , and that death occurred on <i>1/15/67</i> M, from causes and on the date stated above			
22a. SIGNATURE <i>John Smith</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE THEREOF <i>1-18-67</i>	23c. NAME OF CEMETERY OR CREMATORY <i>ST MARGARETS</i>	23d. LOCATION (City or Town) (County) (State) <i>ANNAPOLIS, MD</i>
24. FUNERAL DIRECTOR <i>TS Hardisty 12 Ridge Ave Annapolis, MD</i>		25a REC'D BY REGISTRAR DATE <i>JAN 25 1967</i>	
		25b REGISTRAR'S SIGNATURE <i>James Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

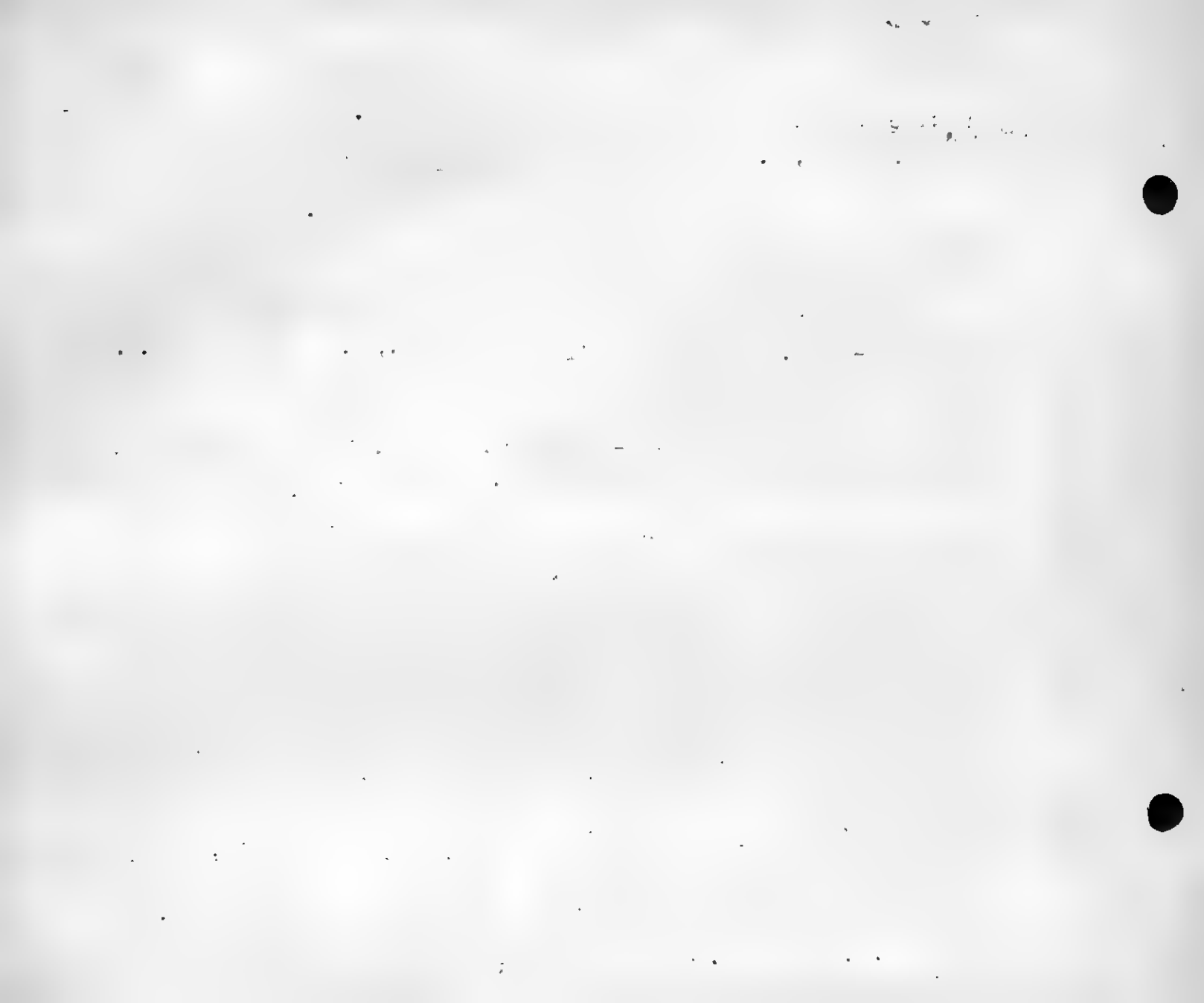


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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
00147									
1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Anne Arundel</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie, Md.</b>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>North Arundel Hospital</b>					d. STREET ADDRESS <b>104 Ridge Rd.</b>				
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Emory</b> Last <b>Merryman</b>					4. DATE OF DEATH Month <b>January</b> Day <b>10</b> Year <b>1967</b>				
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/18/1890</b>		9. AGE (In years last birthday) <b>76</b> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - Supt.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>American Oil</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Balto., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Emory T. Merryman</b>					14. MOTHER'S MAIDEN NAME <b>Genieve Hyle</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>					16. SOCIAL SECURITY NO. <b>215-03-5953</b>		17. INFORMANT Address <b>Mrs. Pansy V. Merryman same address</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO (b) <b>Coronary artery disease</b> DUE TO (c) <b>A.I.N.D.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 9</b> , 19 <b>67</b> to <b>Jan 10</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>Jan 9</b> , 19 <b>67</b> and that death occurred at <b>1:40</b> P.M. from the causes and on the date stated above.									
22a. SIGNATURE <b>Joseph Taler</b>								22b. DATE SIGNED <b>Jan 10, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOSEPH TALER</b>								22d. ADDRESS <b>4514 Hephernest Rd. Glen Burnie, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/13/1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Pikesville, Md.</b>		
24. FUNERAL DIRECTOR <b>Wm. J. Tubner &amp; Sons</b>						25a. REC'D BY REGISTRAR <b>Charles J. Jones</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. Jones</b>	
ADDRESS <b>Balto., Md.</b>						DATE <b>JAN 17 1967</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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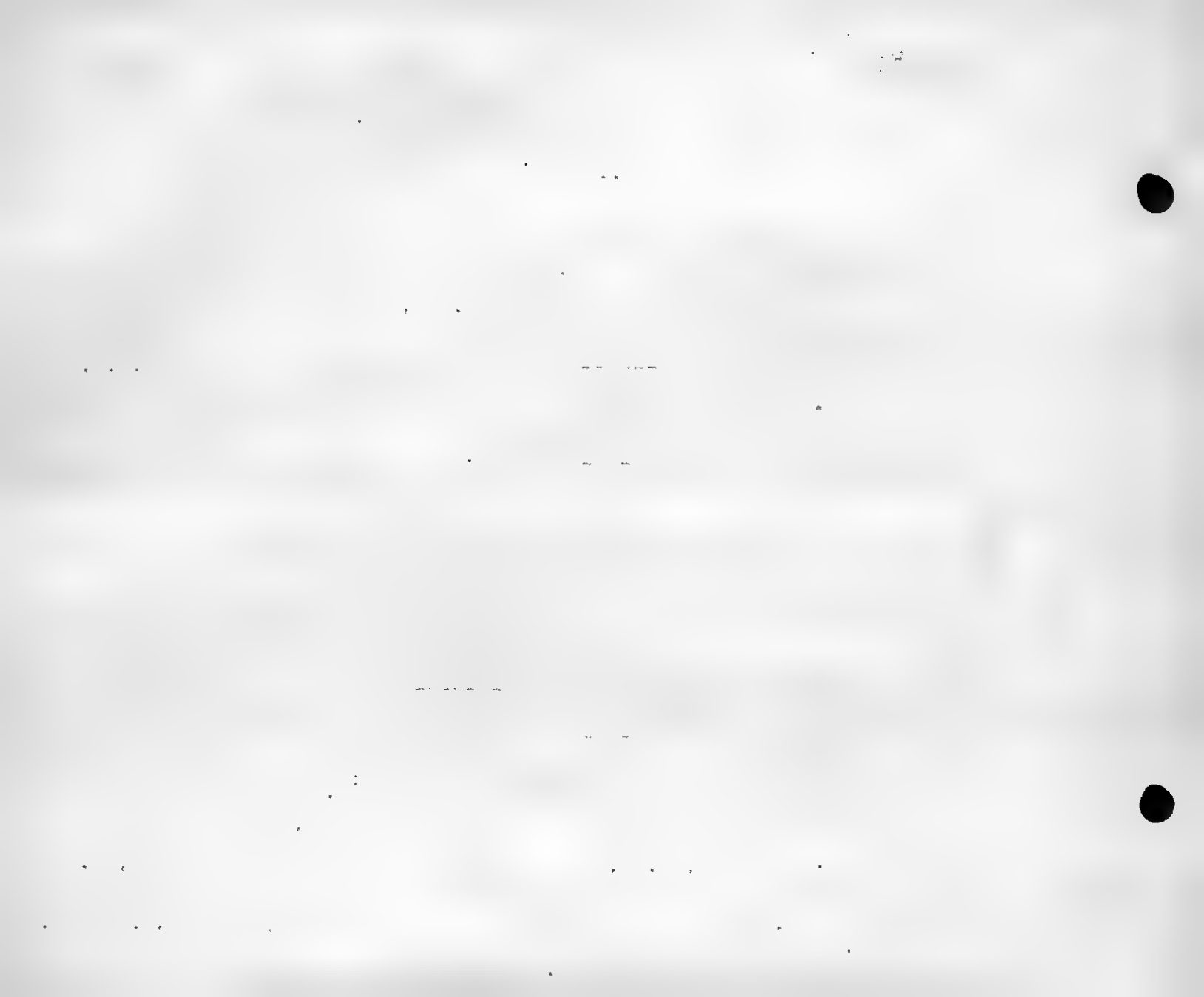
1 (M)

00148

CERTIFICATE OF DEATH

00149

1 PLACE OF DEATH o COUNTY <u>Anne Arundel</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o STATE <u>Maryland</u> b COUNTY <u>Anne Arundel</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>	c LENGTH OF STAY in 16 <u>2 mos. 3 days</u>	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>		d. STREET ADDRESS <u>908 Boucher Avenue</u>	e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) <u>James L. Messick</u>		4. DATE OF DEATH Month <u>1</u> Day <u>30</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Dec. 16, 1908</u>
9 AGE (In years last birthday) <u>58 yrs.</u>		10 IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	11 IF UNDER 24 HRS Hours <u>  </u> Min. <u>  </u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Blacksmith</u>		10b KIND OF BUSINESS OR INDUSTRY <u>-----</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13 FATHER'S NAME <u>James B. Messick</u>	
14 MOTHER'S MAIDEN NAME <u>Mary Ellen Thomas</u>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16 SOCIAL SECURITY NO <u>212-12-9672</u>		17 INFORMANT <u>Hospital Records</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Hemorrhagic Tracheo-Bronchitis</u> DUE TO <u>161X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Confluent Bronchopneumonia, Bilateral</u> DUE TO (c) <u>Carcinoma of Right Aryepiglottic Fold</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>C.B.S. due to Chronic Alcoholism; Cirrhosis of Liver, PTB, healed</u>			
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-----</u>		20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>---</u> p.m. <u>19</u>	
20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-----</u>	
20f. (City or town) (County) (State) <u>-----</u>		21. I certify that (I) (this hospital) attended the deceased from <u>7/16</u> , 19 <u>64</u> , to <u>1/30</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1/30</u> , 19 <u>67</u> , and that death occurred at <u>2:30</u> M., from causes and on the date stated above.	
22a SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>1/30/67</u>	
22c PHYSICIAN'S NAME (Type) <u>L. Benedict, M.D.</u>		22d. ADDRESS <u>Crownsville State Hospital, Md.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>Feb. 2, 1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>Edwards Chapel</u>	23d. LOCATION (City or Town) (County) (State) <u>Riva A.A. Md.</u>
24a FUNERAL DIRECTOR <u>Beverly E. Hopping</u>		25a REC'D BY REGISTRAR <u>[Signature]</u>	
24b ADDRESS <u>Hopping Funeral Home Annapolis, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	
DATE <u>FEB 3 1967</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
15M 4-64

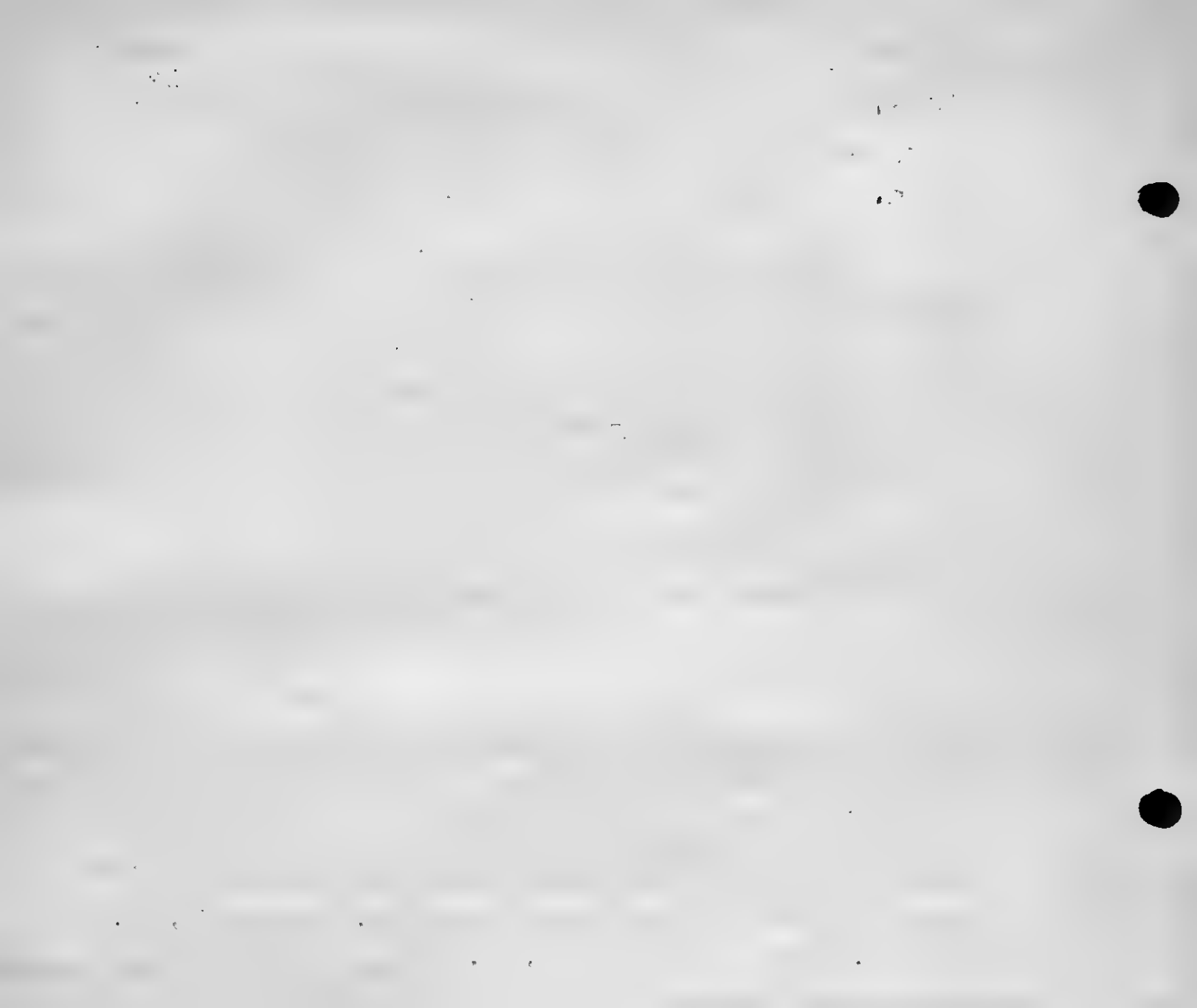
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00149						00150					
1. PLACE OF DEATH a. COUNTY <i>ANNE ARUNDEL</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SEVERNA PARK</i> c. LENGTH OF STAY IN 1b <i>18 years</i> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>RR 2 Box 284</i>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>ANNE ARUNDEL</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Severna Park</i> d. STREET ADDRESS <i>RR 2 Box 284</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <i>ANNA V. MICHAEL</i>						4. DATE OF DEATH Month Day Year <i>1-7-67</i>					
5. SEX <i>FEMALE</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>9-7-81</i>		9. AGE (In years last birthday) <i>83</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Bellevue Ind</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>George Gonnell</i>				14. MOTHER'S MAIDEN NAME <i>Amanda Bent</i>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>(Yes give war or dates of service)</i>			
16. SOCIAL SECURITY NO. <i>---</i>				17. INFORMANT <i>Romanus Miller - Elmore</i>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4500 generalized arteriosclerosis</i> DUE TO <i>Cardiac decompensation</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cardiac decompensation</i> DUE TO (c) <i>Cardiac decompensation</i>										INTERVAL BETWEEN ONSET AND DEATH <i>2 years</i> <i>2 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>none</i>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>2/13, 1962</i> , to <i>1/7, 1967</i> , that (I) (we) last saw the deceased alive on <i>12/19, 1967</i> , and that death occurred at <i>10 AM</i> , from the causes and on the date stated above.											
22a. SIGNATURE <i>R.M. McLaughlin</i>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <i>R.M. McLaughlin</i>						22b. DATE SIGNED <i>1/7/67</i>					
22d. ADDRESS <i>3768 Monmouth Rd. Pasadena, Md.</i>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>1-10-67</i>		23c. NAME OF CEMETERY OR CREMATORY <i>New Haven</i>		23d. LOCATION (City, town or county) (State) <i>New Berlin, Md.</i>			
24. FUNERAL DIRECTOR <i>Robert S. Romano</i>				ADDRESS <i>Severna Park, Md.</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			
DATE <i>JAN 11 1967</i>											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00150				CERTIFICATE OF DEATH				00151			
1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ft G.G. Meade, Maryland</b>						b. COUNTY <b>Anne Arundel</b>					
c. LENGTH OF STAY IN lb <b>DOA</b>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Kimbrough Army Hospital, FCGMMD</b>						d. STREET ADDRESS <b>426 Arbor Drive</b>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <b>Mary</b>			First			Middle <b>Gladys</b>			Last <b>Miller</b>		
4. DATE OF DEATH <b>January 1 1967</b>			Month			Day			Year		
5. SEX <b>Female</b>			6. COLOR OR RACE <b>Cau</b>			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>			8. DATE OF BIRTH <b>25 March 1906</b>		
9. AGE (In years last birthday) <b>60</b> yrs.			IF UNDER 1 YEAR Months Days			IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Fort Dodge, Iowa</b>			
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>Edward Lilly</b>				14. MOTHER'S MAIDEN NAME <b>Nettie Boyer</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>128-09-1746</b>				17. INFORMANT <b>John T. Mc Coy (SIL)</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cancer</b> <b>177.2</b> Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				20. ADDRESS <b>426 Arbor Drive Glen Burnie, Maryland</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				(County)				(State)			
21. I certify that <del>XXXXXX</del> the deceased <del>was</del> <b>DOA at</b> <del>XXXXXX</del> <b>1220, 1 Jan 67, 1220PM</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Frederick J. Bachl</b> M.D.						22b. DATE <b>1 January 1967</b>					
22c. PHYSICIAN'S NAME (Type) <b>Frederick J. Bachl, CPT, MC</b>						22d. ADDRESS <b>Kimbrough Army Hospital, Ft G.G. Meade, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>1/4/1967</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Memorial Pk. Glen Burnie, Md.</b>			
23d. LOCATION (City, town or county) <b>Glen Burnie, Md.</b>				(State)							
24. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond C. Fink</b>						25. REC'D BY REGISTRAR <b>JAN 4 1967</b>					
25b. REGISTRAR'S SIGNATURE <b>Judge</b>											



00151

## CERTIFICATE OF DEATH

00132

1 PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>		d. STREET ADDRESS <b>828 Janice Drive</b>	
3. NAME OF DECEASED (Type or print) <b>James KARL MORELAND</b>		4. DATE OF DEATH Month <b>January</b> Day <b>27</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 18, 1914</b> 52 yrs
9a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <b>PLUMBER RET. U.S. GOV'T</b>		9b. KIND OF BUSINESS OR INDUSTRY <b>Annapolis, Maryland</b>	
10a. BIRTHPLACE (County & State, or foreign country) <b>Annapolis, Maryland</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Annapolis, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		13. FATHER'S NAME <b>JOHN W. MORELAND</b>	
14. MOTHER'S MAIDEN NAME <b>MARGARET Watson</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no, or unknown) (If yes give year or dates of service) <b>YES WW II</b>	
16. SOCIAL SECURITY NO. <b>216-18-5121</b>		17. INFORMANT <b>Mrs. ROBERT C. HUMMEL</b> Address <b>21 EASTERN AVE ANNAPOLIS MD</b>	
18. CAUSE OF DEATH (Enter only one cause for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Presumably Larva in Circulation</b> 581.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1-27-67</b> to <b>1-27, 1967</b> that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>2:50 A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Frank M. Shipley</b>		22b. DATE SIGNED <b>1-27-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>FRANK M. SHIPLEY</b>		22d. ADDRESS <b>Annapolis - Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>1-29-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>HILLCREST CEM.</b>	23d. LOCATION (City or Town) (County) (State) <b>ANNAPOLIS MD.</b>
24. FUNERAL DIRECTOR <b>JOHN M. TAYLOR - SON ANNAPOLIS MD</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 30 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>James Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00152

CERTIFICATE OF DEATH

00154

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Margarets</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. MARGARETS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BROADNECK RD.</u>		e. STREET ADDRESS <u>BROADNECK RD</u>	
3. NAME OF DECEASED (Type or print) <u>LENA</u> First <u>B.</u> Middle <u>MORTON</u> Last		4. DATE OF DEATH Month <u>1</u> Day <u>19</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-31-1890</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>LAUREL, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Gustave Smith</u>		14. MOTHER'S MAIDEN NAME <u>Minnie ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>  </u>	
17. INFORMANT <u>HELEN M. PUTNAM</u> Address <u>MAYO, MD.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO (b) <u>Coronary occlusion</u> DUE TO (c) <u>Arteriosclerotic cardiovascular disease</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>few hour</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>  </u> , 19 <u>  </u> , to <u>  </u> , 19 <u>  </u> , that (I) (we) last saw the deceased alive on <u>  </u> , 19 <u>  </u> , and that death occurred at <u>2 AM</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>Ray Smith</u>		22b. DATE SIGNED <u>1-19-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>RAY SMITH</u>		22d. ADDRESS <u>SEVERNA PARK MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>1-23-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ANNAPOLIS NATIONAL</u>	23d. LOCATION (City or Town) (County) (State) <u>ANNAPOLIS A.A. MD.</u>
24. FUNERAL DIRECTOR <u>John M. Lopez &amp; Sons</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>JAN 24 1967</u>	



00153

## CERTIFICATE OF DEATH

00155

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN 1d <b>4 months</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Crownsville State Hospital</b>		d. STREET ADDRESS <b>Box 327 - Beverly Beach</b>	
3. NAME OF DECEASED (Type or print) <b>#33182 Joseph H. Murphy</b>		4. DATE OF DEATH Month <b>1</b> Day <b>3</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/5/94</b>
9. AGE (In years last birthday) <b>72</b>		IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HRS Hours _____ Min _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fed. Gov. (ret.)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Murphy</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>5271</b> IMMEDIATE CAUSE (a) <b>Respiratory Insufficiency</b> DUE TO (b) <b>Emphysema; Bronchectasis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>Bronchopneumonia</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CBS with Cerebral Arteriosclerosis</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-----</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-----</b>	20f. (City or town) (County) (State) <b>-----</b>
21. I certify that (I) (this hospital) attended the deceased from <b>9/2/</b> , 1966, to <b>1/3/</b> , 1967, that (I) (we) last saw the deceased alive on <b>1/3/</b> , 1967, and that death occurred at <b>9 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>[Signature]</b>		22b. DATE SIGNED <b>1/4/68</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. Benedict, M.D.</b>		22d. ADDRESS <b>Crownsville State Hospital, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>1-7-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>	23d. LOCATION (City or town) (County) (State) <b>Smithland and</b>
24. FUNERAL DIRECTOR <b>Lee Funeral Home</b>		25. REC'D BY REGISTRAR DATE <b>JAN 6 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



00154

## CERTIFICATE OF DEATH

00156

1. PLACE OF DEATH a. COUNTY <b>AA</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>AA</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Norfolk Arundel Hospital</b>		d. STREET ADDRESS <b>7471 Furnace Branch Rd. Glen Burnie, Md</b>	
3. NAME OF DECEASED (Type or print) First <b>Ruth</b> Middle <b>Eda</b> Last <b>Music</b>		4. DATE OF DEATH Month <b>January</b> Day <b>29</b> Year <b>19 67</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-04-06</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School Teacher (Ret.) (A.A. Co. Schools)</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>60</b> yrs
11. BIRTHPLACE (County & State, or foreign country) <b>Tenn (Cumberland Co.)</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Music</b>		14. MOTHER'S MAIDEN NAME <b>Mary Margaret Richards</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Mrs. Thelma M. Lowe (sister) Same as #2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <b>332X</b> IMMEDIATE CAUSE (a) <b>Cerebral Catalepsy - Progressive</b> DUE TO (b) <b>Cerebral Embolism - Basilar Artery</b> DUE TO (c) <b>None</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>JAN 27, 1967</b> , to <b>JAN 29, 1967</b> , that (I) (we) last saw the deceased alive on <b>JAN 29, 1967</b> , and that death occurred at <b>7:35 P.M.</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>E. Carlos E. Arrabal</b>		22b. DATE SIGNED <b>1-29-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>CARLOS E ARRABAL</b>		22d. ADDRESS <b>2705 MOUNTAIN RD-PASADENA 21122.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Feb. 1, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Crossville City Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Crossville, Tenn.</b>
24. FUNERAL DIRECTOR <b>Eugene B. Fleming</b>		25a. REC'D BY REGISTRAR <b>DATE JAN 31 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be recanted within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
00155 1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL					00157 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ANNAPOLIS			c. LENGTH OF STAY IN 1b 4 days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ANNAPOLIS					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) NAVAL HOSPITAL					d. STREET ADDRESS RFD #5 Box 295			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First MIDDLE Last JOSEPH GEORGE NEIMAN			4. DATE OF DEATH Month Day Year 31 January 19 67							
5. SEX Male		6. COLOR OR RACE Cauc.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7 October 1894		9. AGE (In years last birthday) 72 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LT USN RET			10b. KIND OF BUSINESS OR INDUSTRY NAVY RET		11. BIRTHPLACE (County & State, or foreign country) Hickory Ridge, Pa.			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME August Neiman					14. MOTHER'S MAIDEN NAME Pauline Hirsch					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes			16. SOCIAL SECURITY NO. 32		17. INFORMANT Anna E. Neiman (Wife)		Address RFD 5, Box 295 Annapolis, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Branchopneumonia</u> DUE TO (b) <u>Chronic lung disease with fibrosis</u> DUE TO (c) <u>and retained foreign material</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>27 JAN</u> , 19 <u>67</u> , to <u>31 JAN</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>31 Jan</u> 19 <u>67</u> , and that death occurred at <u>2310M</u> , from the causes and on the date stated above.										
22a. SIGNATURE <u>W. P. Arentzen</u>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2-1-67</u>			
22c. PHYSICIAN'S NAME (Type) W. P. ARENTZEN, CAPT MC USN					22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVALS (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2-4-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ST. MARGARETS</u>			23d. LOCATION (City, town or county) (State) <u>ST. MARGARETS MD.</u>			
24. FUNERAL DIRECTOR <u>John M. Taylor &amp; Son</u>					ADDRESS <u>Annapolis, Md.</u>		25a. REC'D BY REGISTRAR <u>FEB 6 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



00156

## CERTIFICATE OF DEATH

00158

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL- GLEN BURNIE</b>		c. LENGTH OF STAY IN lb <b>12 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>NORTH ARUNDEL</b>		d. STREET ADDRESS <b>113 MAGNOLIA AVE.</b>	
3. NAME OF DECEASED (Type or print) First <b>MADELINE</b> Middle <b>OAKES</b> Last <b>OAKES</b>		4. DATE OF DEATH Month <b>JANUARY</b> Day <b>8</b> Year <b>19 67</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCTOBER 31, 1897</b>
9. AGE (In years lost birthday) <b>69 yrs</b>		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>9</b> Hours <b>1</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Karrena</b>		14. MOTHER'S MAIDEN NAME <b>Connell</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO <b>215-32-6634</b>	
17. INFORMANT <b>Alden W. Oakes - Same as # 2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Infantile obstruction</b> DUE TO (b) <b>severed peritonitis, meningitis</b> DUE TO (c) <b>Small bowel intussusception</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 28, 1966</b> , to <b>Jan 8, 1967</b> , that (I) (we) last saw the deceased alive on <b>Jan 7, 1967</b> , and that death occurred at <b>12:10 PM</b> , from causes and on the date stated above			
22a. SIGNATURE <b>Senio Santos</b>		22b. DATE SIGNED <b>1, 8, 67</b>	
22c. PHYSICIAN'S NAME (Type) <b>ARSENIO-SANTOS</b>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/11/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Memorial Pk.</b>		23d. LOCATION (City or Town) (County) (State) <b>Glen Burnie, Md.</b>	
24. FUNERAL DIRECTOR <b>Robert P. ...</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 11 1967</b>	
ADDRESS <b>Glen Burnie, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If July delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

<div>Item 19 Form 588 4-24-67</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div>														
00157					MEDICAL EXAMINER'S CERTIFICATE OF DEATH					00159				
1 PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND					2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Anne Arundel</b>									
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Annapolis</b>			c LENGTH OF STAY IN 1b		c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Annapolis</b>			d STREET ADDRESS <b>Rte.5 Box 30</b>			e RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General</b>														
3 NAME OF DECEASED (Type or print) First <b>Gertrude</b> Middle <b>Owens</b> Last <b>Owens</b>					4. DATE OF DEATH Month <b>1</b> Day <b>10</b> Year <b>19 67</b>									
5 SEX <b>female</b>		6 COLOR OR RACE <b>colored</b>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <b>12/12/1926</b>		9. AGE (In years last birthday) yrs <b>40</b>		IF UNDER 1 YEAR Months <b>1</b> Days <b>10</b>		F UNDER 24 HRS Hours <b>19</b> Min <b>67</b>		
10a USUAL OCCUPATION (Give kind of work done during most of working life, or if retired)				10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) <b>Annapolis, Md.</b>				12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13 FATHER'S NAME <b>Edward Little</b>					14 MOTHER'S MAIDEN NAME <b>Jeannette Johnson</b>									
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown) (If yes give war or dates of service) <b>No</b>					16 SOCIAL SECURITY NO		17 INFORMANT <b>George C. Owens - Anna, Md.</b>			Address				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <b>581.0 Fatty alteration of liver</b> IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH				
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										Partial Autopsy		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)									
20c TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.			20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)							
21 I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					22. DATE SIGNED <b>1/10/67</b>				
EXAMINER'S NAME (Type)					ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>									
					DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					Address (Street city town, or county)				
23a BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>			23b DATE THEREOF <b>1/14/67</b>		23c NAME OF CEMETERY OR CREMATORY <b>Broadneck</b>			23d LOCATION (City or Town) (County) (State) <b>St. Margaret, Md.</b>						
24 FUNERAL DIRECTOR <b>William Reese, Jr - Anna, Md.</b>					ADDRESS		25a REC'D BY REGISTRAR DATE <b>Jan 11 1967</b>			25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>				



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (9)  
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00158

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00160

1 PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Barn</b>		c. LENGTH OF STAY IN 1b <b>468</b>		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gibson Island</b>		d. STREET ADDRESS <b>1221</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>HENRY L. PARKER</b>			4 DATE OF DEATH Month <b>1</b> Day <b>4</b> Year <b>1967</b>						
5 SEX <b>Male</b>		6 COLOR OR RACE <b>Negro</b>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (in years last birthday) <b>23 yrs</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country)			12 CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT			Address		
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY <b>976X</b> IMMEDIATE CAUSE (a) <b>Near Contact Shotgun Wound of Chest</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>Shot Self in Chest</b>							
20c. TIME OF INJURY Month, Day, Year <b>8:00</b> Hour <b>am</b> <b>1</b> <b>4</b> <b>1967</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Barn</b>		20f. (City or town) (County) (State) <b>Anne Arundel Md.</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>Charles S. Petty</b>		EXAMINER'S NAME (Type) <b>Charles S. Petty</b>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <b>1/5/67</b>	
23a. BURIAL (CREMATION REMOVAL) (Specify)		23b. DATE TIME OF		23c. NAME OF CEMETERY OR CREMATORY <b>U of Md. Med. School</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>			
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR DATE <b>JAN 23 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles S. Petty</b>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00161

00159

1 PLACE OF DEATH a COUNTY <b>Anne Arundel</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Anne Arundel</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgewater</b>		c LENGTH OF STAY IN 1b <b>Edgewater</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Beach Drive, Selby Bay</b>		d STREET ADDRESS <b>Beach Drive, Delby Bay</b>	
3 NAME OF DECEASED (Type or print) <b>AKA WATHER</b> Middle <b>WALTER</b> Last <b>F. PARRISH</b>		4 DATE OF DEATH Month <b>January</b> Day <b>23</b> Year <b>19 67</b>	
5 SEX <b>Male</b>	6 CO. OR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> D.VORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>1-28-1929</b>
9 AGE (In years last birthday) <b>38 3/4</b>		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Meat Coter Retail</b>	
11 BIRTHPLACE (State or foreign country) <b>Alabama</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>James A Parrish</b>		14 MOTHER'S MAIDEN NAME <b>Jean Williams</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes give year or dates of service) <b>Yes WWII</b>		16 SOCIAL SECURITY NO <b>422-30-3403</b>	
17 INFORMANT <b>Marylouise Parrish</b>		Address <b>#2</b>	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carbon Monoxide Intoxication and Massive Body Burns.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>716.0</b> (c) <b>XENOX Burns.</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CONFLAGRATION</b>			
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Conflagration</b>	
20c TIME OF INJURY Month, Day, Year Hour <b>XX</b> pm <b>1/23</b> 19 <b>67</b>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f (City or town) (County) (State) <b>Edgewater A.A. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , inspect an <input type="checkbox"/> inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles S. Petty</b>		22. DATE SIGNED <b>1/24/67</b>	
EXAMINER'S NAME (Type) <b>Charles S. Petty</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b DATE THEREOF <b>1-27-67</b>	
23c NAME OF CEMETERY OR CREMATORIUM <b>Arlington National</b>		23d LOCATION (City or town) (County) (State) <b>Arlington V.A.</b>	
24 FUNERAL DIRECTOR <b>John M. Sayla &amp; Sons Annapolis, Md.</b>		25a REC'D BY REGISTRAR DATE <b>JAN 30 1967</b>	
25b REGISTRAR'S SIGNATURE <b>Charles Jones</b>			



00160

CERTIFICATE OF DEATH

00162

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>AA</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>		c. LENGTH OF STAY IN 1b <b>3 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>North Arundel Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>S</b> Last <b>Patrick</b>		4. DATE OF DEATH Month <b>January</b> Day <b>27</b> Year <b>1967</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/30/87</b>
9. AGE (In years lost birthday) <b>80</b> yrs		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>27</b> Hours <b>19</b> Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Farmer</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>Ret. Farmer</b>	
11c. BIRTHPLACE (County & State, or foreign country) <b>Russell Co. - Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James R. Patrick</b>		14. MOTHER'S MAIDEN NAME <b>Sally Hess</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>227-05-9797</b>	
17. INFORMANT <b>Mrs. Paul E. Bonovich, Gettysburg, Pa. R-1</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>A. S. C. U. D.</b> DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 15, 1966</b> to <b>Jan 27, 1967</b> , that (I) (we) last saw the deceased alive on <b>Sept 17, 1967</b> , and that death occurred at <b>7:35 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Robert Dabolin</b>		22b. DATE SIGNED <b>1-27-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>ROBERT DABOLIN, M.D.</b>		22d. ADDRESS <b>400 CRAN HWAY, NW Glen Burnie, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>1/31/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bel Air Memorial Gardens</b>	23d. LOCATION (City or Town) (County) (State) <b>Bel Air, Harford Co., Md.</b>
24. FUNERAL DIRECTOR <b>Richard A. Little</b>		25a. REC'D BY REGISTRAR <b>Littlestown, Pa.</b>	
25b. REGISTRAR'S SIGNATURE <b>James Judge</b>		DATE <b>JAN 30 1967</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00161					00163				
1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> c. LENGTH OF STAY IN b <b>over 30 yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>72 Clay Street</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> d. STREET ADDRESS <b>72 Clay Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>THOMAS NMN</b> Middle <b>PERRY</b> Last			4. DATE OF DEATH Month <b>Jan.</b> Day <b>5</b> Year <b>1967</b>						
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 3-1894</b>		9. AGE (In years last birthday) <b>73</b> yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Construction laborer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>			12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>					14. MOTHER'S MAIDEN NAME <b>Unknown</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <b>No</b> (If yes give war or dates of service)			16. SOCIAL SECURITY NO. <b>214-05-1822</b>		17. INFORMANT Address <b>Anna Belle Johnson-111 Obery Crt. Annapolis, Maryland</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA, SIGMOID COLON, WITH METASTASES</b> 153.3 DUE TO <b>TO LUNGS AND ABDOMINAL VISCERA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>AT LEAST 2 1/2 YEARS</b> DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>8-15</b> , 19 <b>64</b> , to <b>1-5</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>1-2-67</b> 19 <b>67</b> , and that death occurred at <b>1:17 PM</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>Antonio L. Kison</b>					22b. DATE SIGNED <b>1-11-67</b>				
22c. PHYSICIAN'S NAME (Type) <b>A.L.KISON</b>					22d. ADDRESS <b>1407 Forrest Drive Annapolis, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan. 9-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Brewer Hill</b>			23d. LOCATION (City, town or county) (State) <b>Annapolis, Maryland</b>		
24. FUNERAL DIRECTOR <b>C.E.Hicks 111 Annapolis, Md.</b>					25a. REC'D BY REGISTRAR <b>JAN 11 1967</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				



00162

Items 13, 14 Film 3385 2/14/67 mh

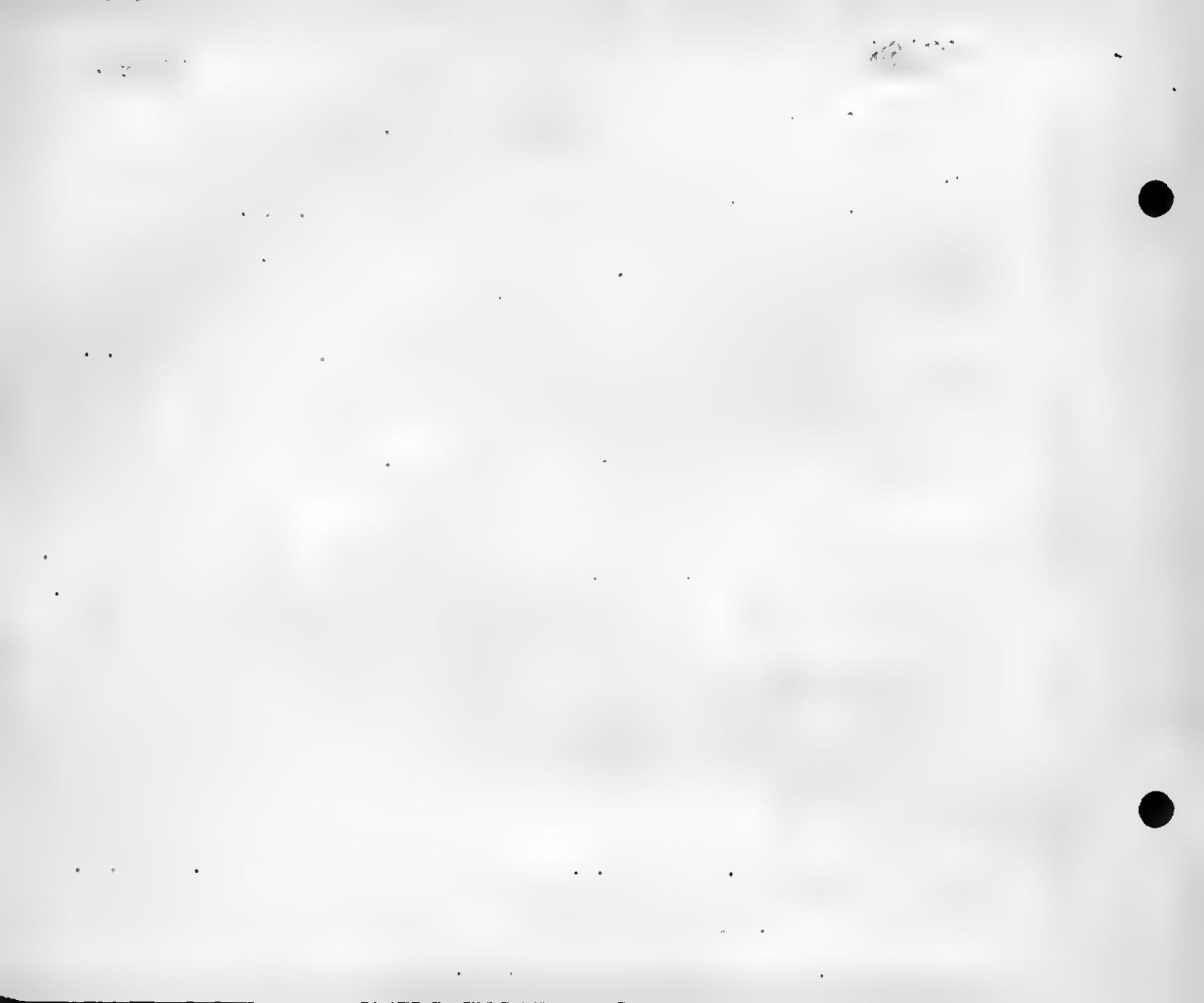
## CERTIFICATE OF DEATH

00164

1. PLACE OF DEATH a. <b>COUNTEE ARUNDEL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>ANNE ARUNDEL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GLEN BURNIE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GLEN BURNIE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>NORTH ARUNDEL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WILBUR</b> Middle <b>C.</b> Last <b>PHELPS</b>		4. DATE OF DEATH Month <b>JANUARY</b> Day <b>23</b> Year <b>67</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-16-93</b>
9. AGE (In years last birthday) <b>73 yrs.</b>		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED- BAR OWNER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>BROOKLYN, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME <b>Rufus D. (unknown) Phelps</b>		14. MOTHER'S MAIDEN NAME <b>(unknown) Mollie Cromwell</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>WWII Yes</b>		16. SOCIAL SECURITY NO <b>216-28-9924</b>	
17. INFORMANT <b>Mrs Ruth M. Phelps (Wife)</b>		Address <b>Same as #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY <b>197.4 ACUTE GASTRIC DILATATION</b> IMMEDIATE CAUSE (a) <b>GENERALIZED CARCINOMATOSIS</b> DUE TO (b) <b>RHABDOMYOSARCOMA</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>SEVERAL MINUTES</b> <b>3 MOS.</b> <b>1 YR.</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input checked="" type="checkbox"/> <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12-5-66</b> , 19__, to <b>1-23-67</b> , 19__, that (I) (we) last saw the deceased alive on <b>1-23-67</b> , 19__, and that death occurred at <b>1:10 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>at Annie Beum</b>		22b. DATE SIGNED <b>1-23-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>MAURICE J. BERMAN, M.D.</b>		22d. ADDRESS <b>614 MEDICAL ARTS BDLG. BALT., MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Jan. 26, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Nat'l Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR <b>Richard V. Singleton</b>		25a. REC'D BY REGISTRAR <b>Glen Burnie, Md.</b>	
25b. REGISTRAR'S SIGNATURE <b>DATE JAN 26 1967</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



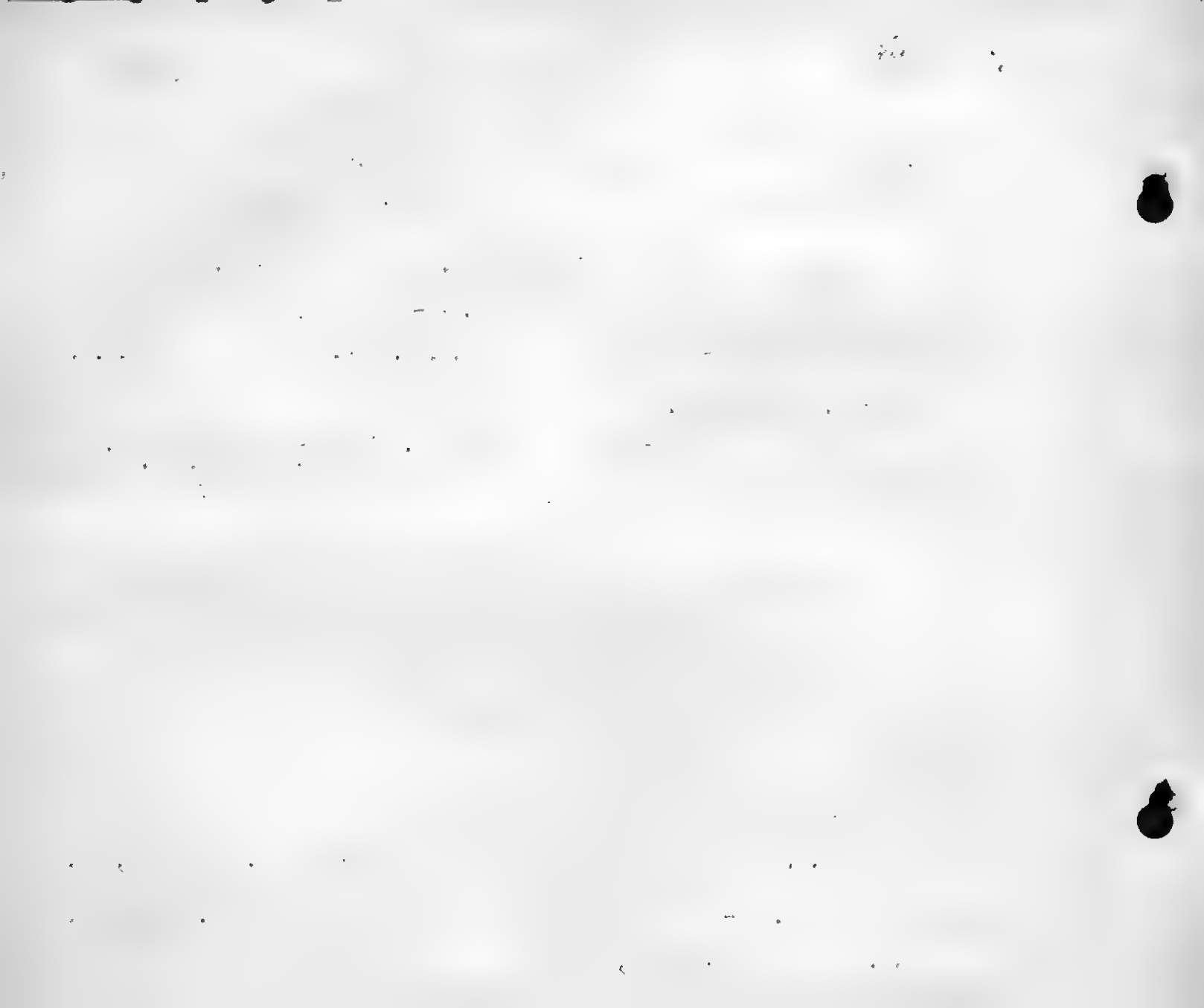
1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

00163

00165

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Anne Arundel</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> c. LENGTH OF STAY IN 1b <b>life</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>208 Eastern Avenue</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> d. STREET ADDRESS <b>208 Eastern Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>ROBERT EDWARD PINDELL Jr.</b> First Middle Last			<b>4. DATE OF DEATH</b> <b>Jan. 10 1967</b> Month Day Year				
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>Negro</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>Mar. 22-1894</b>	<b>9. AGE</b> (In years last birthday) <b>72</b> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Construction Laborer - retired</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b>		
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>A.A.Co. Maryland</b>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>				
<b>13. FATHER'S NAME</b> <b>Robert E. Pindell Sr.</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Carrie ?</b>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <b>214-05-1880 A</b>		<b>17. INFORMANT</b> <b>Birdie H. Pindell-208 Eastern Ave. Annapolis, Md.</b> Address			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <b>Quincke / fracture with</b> <b>177X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>metastasis to vertebral regions</b> (c) _____ <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, notify medical examiner) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year <b>19</b> Hour a.m. _____ p.m. _____ <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>							
<b>21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <b>A.T. Allen</b>				<b>22b. DATE SIGNED</b> <b>JAN 17 1967</b>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>A.T. Allen</b>				<b>22d. ADDRESS</b> <b>Cathedral St. Annapolis, Md.</b>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>Jan. 14-67</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Pine Lawn</b>			
<b>23d. LOCATION</b> (City, town or county) (State) <b>Bestgate Rd. Annapolis, Md</b>		<b>25a. REC'D BY REGISTRAR</b> <b>Charles Judge</b> <b>DATE</b> <b>JAN 17 1967</b>					
<b>25b. REGISTRAR'S SIGNATURE</b>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
00164		CERTIFICATE OF DEATH	
1. PLACE OF DEATH a. COUNTY Anne Arundel Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Md. b. COUNTY A.A.Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie	c. LENGTH OF STAY IN 1b 15 Days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Box 352 Blvd. Park, Pasadena, A.A. Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Robert E. Ravel Sr.		4. DATE OF DEATH Month Jan. Day 28 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/17/1900
9. AGE (In years last birthday) 66 56 yrs		10. IF UNDER 1 YEAR Months 8 Days 11	11. IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor		10b. KIND OF BUSINESS OR INDUSTRY Shipbuilding	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joseph Ravel		14. MOTHER'S MAIDEN NAME Ward	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO. 218-03-7885	
17. INFORMANT Margaret Ravel (Wife)		Address As Above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Renia 2d</i> DUE TO (b) <i>Carcinoma Bladder</i> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above			
22a. SIGNATURE <i>[Signature]</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1/31/1967	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Brooklyn A. A. Md.
24. FUNERAL DIRECTOR Raymond C. Fink		25a. REC'D BY REGISTRAR DATE JAN 31 1967	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		25c. REGISTRAR'S NAME Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 to be retained by the hospital or attending physician. In by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7-62

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00165					00167				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)				
a. COUNTY <u>Anne Arundel</u>					a. STATE <u>Maryland</u> b. COUNTY <u>A. A.</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>North Linthicum</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>North Linthicum</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>10 Hampton Road</u>					d. STREET ADDRESS <u>10 Hampton Road 21090</u>				
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First <u>Hilda</u> Middle <u>C.</u> Last <u>Reynolds</u>					Month <u>January</u> Day <u>18</u> Year <u>1967</u>				
5. SEX <u>Female</u>					6. COLOR OR RACE <u>White</u>				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <u>1898</u>				
9. AGE (In years last birthday) <u>68</u> yrs.					10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>				
11. IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>					12. CITIZEN OF WHAT COUNTRY?				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>				
13. FATHER'S NAME <u>Christopher C. Barnsley</u>					14. MOTHER'S MAIDEN NAME <u>Mary Anderson</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>					16. SOCIAL SECURITY NO. <u>None</u>				
17. INFORMANT <u>Miss Edna Reynolds</u>					Address <u>same address as above</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Chronic Pyelonephritis</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <u>March</u> , 19 <u>66</u> , to <u>Jan</u> , 19 <u>67</u> , that (I) ( <u>we</u> ) last saw the deceased alive on <u>13 Jan</u> , 19 <u>67</u> , and that death occurred at <u>5 P</u> M, from the causes and on the date stated above									
22a. SIGNATURE <u>W. K. Gallager, Jr.</u> M.D. 22b. DATE SIGNED									
22c. PHYSICIAN'S NAME (Type) <u>W. K. Gallager, Jr., M.D.</u> 22d. ADDRESS <u>6630 Baltimore National Pike. Balto. 21228</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u> 23b. DATE THEREOF <u>1/21/1967</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>									
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tubman &amp; Sons</u> ADDRESS <u>Baltimore, Md.</u> 25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> DATE <u>JAN 20 1967</u>									



00166

## CERTIFICATE OF DEATH

00168

1 PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN 1b <b>4 months</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Piney Point</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Crownsville State Hospital</b>		d. STREET ADDRESS <b>St. George Island</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3 NAME OF DECEASED (Type or print) <b>#33254 Norman I. Rice</b>		4. DATE OF DEATH Month <b>1</b> Day <b>9</b> Year <b>1967</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/18/93</b>
9. AGE (in years last birthday) yrs <b>73</b>		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Oyster Business</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	11 BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Charles Rice</b>	
14. MOTHER'S MAIDEN NAME <b>Mary-H. Chesler</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)	
16. SOCIAL SECURITY NO <b>Unknown</b>		17. INFORMANT <b>Hospital Records</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <b>471X</b> IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Brain Syndrome sec. Arteriosclerosis</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-----</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>10</b> p.m. <b>-----</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-----</b>	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>9/9/66</b> , to <b>1/9/1967</b> , that (I) (we) last saw the deceased alive on <b>1/9/1967</b> , and that death occurred at <b>10:PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Norman I. Benedict</b>		22b. DATE SIGNED <b>1/10/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. Benedict, M.D.</b>		22d. ADDRESS <b>Crownsville State Hospital, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>1-12-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St George M.E. Church</b>	23d. LOCATION (City or Town) (County) (State) <b>St George's Island Md.</b>
24. FUNERAL DIRECTOR <b>W. Clarke Mattingley, Leonardtown Md.</b>		25a. REC'D BY REGISTRAR <b>DATE JAN 11 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



00167

## CERTIFICATE OF DEATH

00169

1 PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Airyville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis, MD.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Knottwood Nursing Home</u>		d. STREET ADDRESS <u>600 BURNSIDE ST.</u>	
3 NAME OF DECEASED (Type or print) <u>Henry Nelson ROANE, Sr.</u>		4 DATE OF DEATH Month <u>1</u> Day <u>10</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Jan. 25, 1882</u>
9. AGE (In years last birthday) <u>84</u> yrs		10 IF UNDER 1 YEAR Months <u>10</u> Days <u>19</u> Hours <u>67</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LUMBER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HARDWARE</u>	
11 BIRTHPLACE (County & State or foreign country) <u>CASH, Virginia</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Henry H. Roane</u>		14. MOTHER'S MAIDEN NAME <u>MARINETTA GRAY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>H. NELSON ROANE JR.</u>		Address <u>#2</u>	

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>430.1</u> IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO <u>Coronary artery occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Arteriosclerotic Cardiovascular disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>few hours</u>
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PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that (I) (If deceased) attended the deceased from <u>1966</u> , to <u>1967</u> , that (I) <u>did</u> last saw the deceased alive on <u>1967</u> , and that death occurred at <u>1967</u> M, from causes and on the date stated above.	
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22a. SIGNATURE <u>Ray M. Smith</u>	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>1-11-67</u>
22c. PHYSICIAN'S NAME (Type) <u>Ray M. Smith, M.D.</u>	22d. ADDRESS <u>Hahn Prof Bldg., Severna Park, Md.</u>	

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>1-12-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Woodhawn</u>	23d. LOCATION (City or Town) (County) (State) <u>BALTO MD.</u>
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24. FUNERAL DIRECTOR <u>John M. L. &amp; Sons Annapolis, Md.</u>	25a. REC'D BY REGISTRAR <u>JAN 10 1967</u>	25b. REGISTRAR'S SIGNATURE <u>James J. Judge</u>
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



00168

## CERTIFICATE OF DEATH

00170

1 PLACE OF DEATH a. COUNTY <u>A. A. Co.</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A. A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>WEEMS CREEK</u>		c. LENGTH OF STAY IN 1b <u>WEEMS CREEK</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>105 Wilson Road</u>		d. STREET ADDRESS <u>105 Wilson Road</u>	
3 NAME OF DECEASED (Type or print) <u>MAUD</u> First <u>E. ROGERS</u> Middle Last		4 DATE OF DEATH Month <u>1</u> Day <u>21</u> Year <u>1967</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>11-16-1878</u>
9 AGE (In years) <u>88</u> yrs		10 IF UNDER 1 YEAR Months <u>1</u> Days <u>21</u> Hours <u>19</u> Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11 BIRTHPLACE (County & State or foreign country) <u>ARLINGTON MD.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13 FATHER'S NAME <u>CAVIN O. DITCH</u>		14 MOTHER'S MAIDEN NAME <u>HARRIETT MOORE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>MILDEED R. MYERS #2</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>15 YRS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 HOUR</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>JUNE</u> , 19 <u>36</u> , to <u>JULY</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>15-JULY</u> 19 <u>67</u> , and that death occurred at <u>1039 PM</u> , from causes on and on the date stated above.			
22a SIGNATURE <u>Edward S. Beck</u> M.D.		22b. DATE SIGNED <u>1-23-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>EDWARD S. BECK</u>		22d. ADDRESS <u>75 FRANKLIN ST. ANNAPOLIS, MD.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1-24-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>LORRAINE CEMT.</u>		23d. LOCATION (City or Town) (County) (State) <u>BALTO MD.</u>	
24. FUNERAL DIRECTOR <u>John M. Taylor &amp; Sons</u>		25a REC'D BY REGISTRAR DATE <u>JAN 24 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>John M. Taylor &amp; Sons</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00169

## CERTIFICATE OF DEATH

00171

1 PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN lb <b>11 mos. 15 das.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Crownsville State Hospital</b>		d. STREET ADDRESS <b>703 E. Chase Street</b>	
3 NAME OF DECEASED (Type or print) <b>#31153 James Roundtree</b>		4 DATE OF DEATH Month <b>1</b> Day <b>5</b> Year <b>1967</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>Negro</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>2/5/1896</b>
9 AGE (In years last birthday) yrs. <b>70</b>		IF UNDER 1 YEAR Months _____ Days _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Radio Tech. (ret.)</b>		10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (County & State, or foreign country) <b>North Carolina</b>
13. FATHER'S NAME <b>Martin Roundtree</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>Unknown</b>	17. INFORMANT <b>Hospital Records</b>
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>351X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebrovascular Accident</b> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Chronic Brain Syndrome - Inanition and Diabetes Mellitus</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year hour a.m. _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	20f. (City or town) (County) (State) -----
21. I certify that (I) (this hospital) attended the deceased from <b>1/20/</b> , 1966, to <b>1/5/</b> , 1967, that (I) (we) last saw the deceased alive on <b>1/5/</b> 1967, and that death occurred at <b>1:30</b> M, from causes and on the date stated above			
22a. SIGNATURE <i>L. Benedict</i>		22b. DATE SIGNED <b>1/5/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. Benedict, M.D.</b>		22d. ADDRESS <b>Crownsville State Hospital, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE THEREOF <b>1-26-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Union Med. School</b>	23d. LOCATION (City or Town) (County) (State) <b>BAIT, Md.</b>
24. MEDICAL DIRECTOR <b>William Reese Jr</b>		25a. REC'D BY REGISTRAR <b>JAN 27 1967</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



00170

## CERTIFICATE OF DEATH

00172

1. PLACE OF DEATH a COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a STATE <u>MD.</u> b COUNTY <u>H.A.</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOHIS</u>		c LENGTH OF STAY IN 1b <u>129 CONDUIT ST.</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>129 CONDUIT ST.</u>		d STREET ADDRESS <u>129 CONDUIT ST.</u>	
3. NAME OF DECEASED (Type or print) First <u>TANET</u> Middle <u>L.</u> Last <u>SABALOT</u>		4. DATE OF DEATH Month <u>1</u> Day <u>7</u> Year <u>1967</u>	
5 SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>12-18-1897</u>
10a USUAL OCCUPATION (Give kind of work done during most of work ng life, even if retired) <u>HOUSEWIFE</u>		10b KIND OF BUSINESS OR INDUSTRY <u>HOME-</u>	9 AGE (In years last birthday) yrs <u>69</u>
11 BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE, MD.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ALFRED BAGBY JR.</u>		14. MOTHER'S MAIDEN NAME <u>TANET CAMPBELL</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>ABEL C. J. SABALOT</u>	
17. INFORMANT <u>ABEL C. J. SABALOT</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>Coronary Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Arteriosclerotic Heart Disease</u> (c) <u>Coronary Arteriosclerotic Heart Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2-12-</u> 19 <u>63</u> to <u>7-27</u> 19 <u>65</u> , that (I) <del>(we)</del> last saw the deceased alive on <u>7-27</u> 19 <u>65</u> , and that death occurred at <u>7:00 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>M. F. Stephens</u>		22b. DATE SIGNED <u>9 Jan. 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>M. F. Stephens</u>		22d. ADDRESS <u>38 Cornhill Annapolis Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>1-11-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>U.S. NAVAL ACADEMY</u>	23d. LOCATION (City or town) (County) (State) <u>ANNAPOHIS H.A. MD.</u>
24. FUNERAL DIRECTOR <u>John M. ... Annapolis, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 12 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 2 Film 3435 1/24/67 mh

CERTIFICATE OF DEATH

00172

00173

1 PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c LENGTH OF STAY IN 1b <b>11/24/67</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>		d STREET ADDRESS <b>24 Old Annapolis Rd.</b> <b>Knoxwood Nursing Home</b>	
3 NAME OF DECEASED (Type or print) <b>Ethel W. SAVAGE</b>		4 DATE OF DEATH <b>January 4 1967</b>	
5 SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>January 17, 1880</b>
9. AGE (in years last birthday) <b>86 yrs</b>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Virginia</b>	
11. BIRTHPLACE (County & State or foreign country) <b>U. S.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John West</b>		14. MOTHER'S MAIDEN NAME <b>Sadie Bundick</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO	
17. INFORMANT <b>Mrs. Nancy Keesey- 24 Old Annapolis Rd.</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> DUE TO (b) <b>Myocardial infarction</b> DUE TO (c) <b>Arteriosclerosis, general &amp; coronary</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 months</b> <b>4 months</b> <b>? years</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic nephrosclerosis with uremia, esophageal stricture, bronchopneumonia, pleural effusion</b>		19 "WAS AUTOPSY PERFORMED?" YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <b>13 December 1966</b> to <b>4 January 1967</b> , that (I) (we) last saw the deceased alive on <b>4 January 1967</b> , and that death occurred at <b>4:20 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Charles W. Kinzer</b>		22b. DATE SIGNED <b>5 January 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Charles W. Kinzer, M. D.</b>		22d. ADDRESS <b>South River Medical Center Edgewater, Maryland 21037</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Jan. 7, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Wachapreague Cemetery</b>	23d. LOCATION (City or town) (County) (State) <b>Accomac Co. Wachapreague, Va.</b>
24 FUNERAL DIRECTOR <b>George J. Gonce-4001 Ritchie Hgwy., Baltimore,</b>		25a. REC'D BY REGISTRAR <b>JAN 9 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00172						00174					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY			ANNE ARUNDEL			a. STATE			b. COUNTY		
			MARYLAND			MARYLAND			ANNE ARUNDEL		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			d. IS RESIDENCE ON A FARM?		
ANNAPOLIS, MARYLAND			7 hr.			ANNAPOLIS			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						d. STREET ADDRESS			e. IS RESIDENCE ON A FARM?		
ANNE ARUNDEL GENERAL HOSPITAL						417 Fourth Street			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH			Month Day Year		
THERESA ELIZABETH SHARPS						1 7 1967					
5 SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR IF UNDER 24 HRS.	
FEMALE		NEGRO		WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		6-9-20		46 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)			
PRESSER								MARYLAND			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				12. CITIZEN OF WHAT COUNTRY?			
HORACE PACK				LOIS V. SHARPS				U.S.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO				17. INFORMANT Address			
								TAKOMA PARK, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid hemorrhage											
Conditions, if any, which gave rise to immediate cause (b) Anteriorly located C.V. disease & hypertension											
(a), stating the underlying cause last. (c) DUE TO											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (e)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)											
20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
Hour a.m. p.m. 19 While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
21. I certify that (I) (this hospital) attended the deceased from Jan 6, 1967 to Jan 7, 1967, that (I) (we) last saw the deceased alive on Jan 7, 1967, and that death occurred at 2:55 P.M. from the causes and on the date stated above.											
22a. SIGNATURE 22b. DATE SIGNED											
Maurice Klawans M.D. 31 SOUTHGATE AV., ANNAPOLIS, MD.											
22c. PHYSICIAN'S NAME (Type or print)											
MURRIE F. KLAUANS											
23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State)											
Burial 1-9-1967 Brewster Hill Cemetery, Annapolis, MD											
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DATE											
William J. Hester, Jr. 1010 N. 10th St. Annapolis, MD Jan 10 1967 Charles Judge											



00173

## CERTIFICATE OF DEATH

00175

1. PLACE OF DEATH a. COUNTY <u>A. A. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A. A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SEVERNA PARK</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ANNAPOLIS NURSING HOME</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>GEORGE SHEPHERD</u>		4. DATE OF DEATH Month <u>1</u> Day <u>19</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-5-1883</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HARDWARE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MERCHANT</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>N. JERSEY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>EDWARD SHEPHERD</u>		14. MOTHER'S MAIDEN NAME <u>EMMA HOPPOCK</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>EDWARD SHEPHERD</u>		Address <u>#2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. <u>42.1</u> IMMEDIATE CAUSE (a) <u>Cardiovascular Endocarditis disease</u> DUE TO (b) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>  </u> DUE TO (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour o m. p m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. (City or town) (County) (State) <u>  </u>
21. I certify that (I) (this hospital) attended the deceased from <u>1963</u> , to <u>1/12, 1967</u> , that (I) (we) last saw the deceased alive on <u>1/12, 1967</u> , and that death occurred at <u>6:30 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Robert W. Peeler</u>		22b. DATE SIGNED <u>1/19/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>R. N. PEELE</u>		22d. ADDRESS <u>CATHEDRAL ST. ANNAPOLIS, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Type) <u>BURIAL</u>	23b. DATE THEREOF <u>1-21-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>DORCHESTER MEMORIAL</u>	23d. LOCATION (City or Town) (County) (State) <u>CAMBRIDGE MD.</u>
24. FUNERAL DIRECTOR <u>John M. Lutz</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>  </u>		DATE <u>JAN 24 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



## CERTIFICATE OF DEATH

00174

00176

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN lb <b>Pasadena</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>		d. STREET ADDRESS <b>18 Brookview Ave.</b>	
3. NAME OF DECEASED (Type or print) <b>Thomas Edward SHERLOCK</b>		4. DATE OF DEATH Month <b>January</b> Day <b>8</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 27, 1891</b>
9. AGE (In years last birthday) <b>75 yrs.</b>		10. BIRTHPLACE (County & State, or foreign country) <b>Annapolis, Maryland</b>	
11. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>THOMAS E. SHERLOCK SR.</b>		14. MOTHER'S MAIDEN NAME <b>Emily TUCKER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WWII</b>		16. SOCIAL SECURITY NO <b>HELEN OLSEN</b>	
17. INFORMANT <b>#2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>pneumonia</b> DUE TO (b) <b>uremia</b> DUE TO (c) <b>Arteriosclerosis &amp; glomerulonephritis</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at <b>8:15 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Ray M. Smith, M.D.</b>		22b. DATE SIGNED <b>1-9-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Ray M. Smith, M.D.</b>		22d. ADDRESS <b>Hahn Prof Bldg., Severna Park, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>1-11-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR Bluff</b>	23d. LOCATION (City or town) (County) (State) <b>Annapolis MD</b>
24. FUNERAL DIRECTOR <b>John M. Taylor &amp; Sons Annapolis, Md.</b>		25a. REC'D BY REGISTRAR <b>JAN 12 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



00175

## CERTIFICATE OF DEATH

00177

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please have carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville</u>		c. LENGTH OF STAY IN 1b <u>7 Mos.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u> <u>12.1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Knollwood Nursing Home, Millersville</u>				d. STREET ADDRESS <u>Jumpers Hole Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Sadie (nmi) Shriver (Schrieber)</u>				4. DATE OF DEATH Month <u>January</u> Day <u>23</u> Year <u>1967</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>Cau.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 24, 1882</u>	9. AGE (In years lost birthday) <u>84</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS Hours <u>  </u> Min <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife (Ret)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Aaron</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Mc Graw</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u> <u>None</u>		16. SOCIAL SECURITY NO <u>Unknown</u>		17. INFORMANT <u>Mrs. Lottie J. Hoyt (daughter)</u> Address <u>Rt. 11-Box 82 Pasadena</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>4521</u> DUE TO (b) <u>arteriosclerotic Cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>3 days</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumonia and congestive heart failure</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 3, 1965</u> , to <u>Jan. 23, 1967</u> , that (I) (we) last saw the deceased alive on <u>Oct. 8, 1966</u> , and that death occurred at <u>11:04 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Ray M. Smith</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Ray M. Smith, M. D.</u>				22d. ADDRESS <u>Hahn Professional Bldg., Severna Pk., Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 25, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Anne Arundel Co. Md.</u>	
24. FUNERAL DIRECTOR <u>Richard V. Singleton</u>				ADDRESS <u>Glen Burnie, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 26 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



## CERTIFICATE OF DEATH

03090

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>_____</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN 1b <u>3yrs. 8mos.</u>		d. STREET ADDRESS <u>1624 Barnes Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>#25200 Edward J. Small</u>		4. DATE OF DEATH <u>1 20 19 67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/12/99</u>
9. AGE (In years last birthday) <u>67</u> yrs		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cement Finisher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>_____</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Small</u>		14. MOTHER'S MAIDEN NAME <u>Hattie</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Hospital Records</u>		Address <u>_____</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary Embolism?</u> <u>4221</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } (b) <u>Arteriosclerotic Cardio-Vascular Disease</u> DUE TO / (c) <u>Chronic Brain Syndrome; Azotomia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>_____</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Chronic Brain Syndrome; Azotomia</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>_____</u>	
20c. TIME OF INJURY Month, Day, Year <u>19 67</u> Hour a.m. <u>_____</u> p.m. <u>_____</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>_____</u>	20f. (City or town) (County) (State) <u>_____</u>
21. I certify that (I) (this hospital) attended the deceased from <u>4/23/ 19 63</u> to <u>1/20/ 19 67</u> that (I) (we) lost saw the deceased alive on <u>1/20/ 19 67</u> , and that death occurred on <u>9:25 P.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>1/23/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. Benedict, M.D.</u>		22d. ADDRESS <u>Crownsville State Hospital, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>_____</u>	23b. DATE THEREOF <u>11-6-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Woodland Med. School</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md.</u>
24. FUNERAL DIRECTOR <u>William Reese II 108 W. Washington St.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



00176

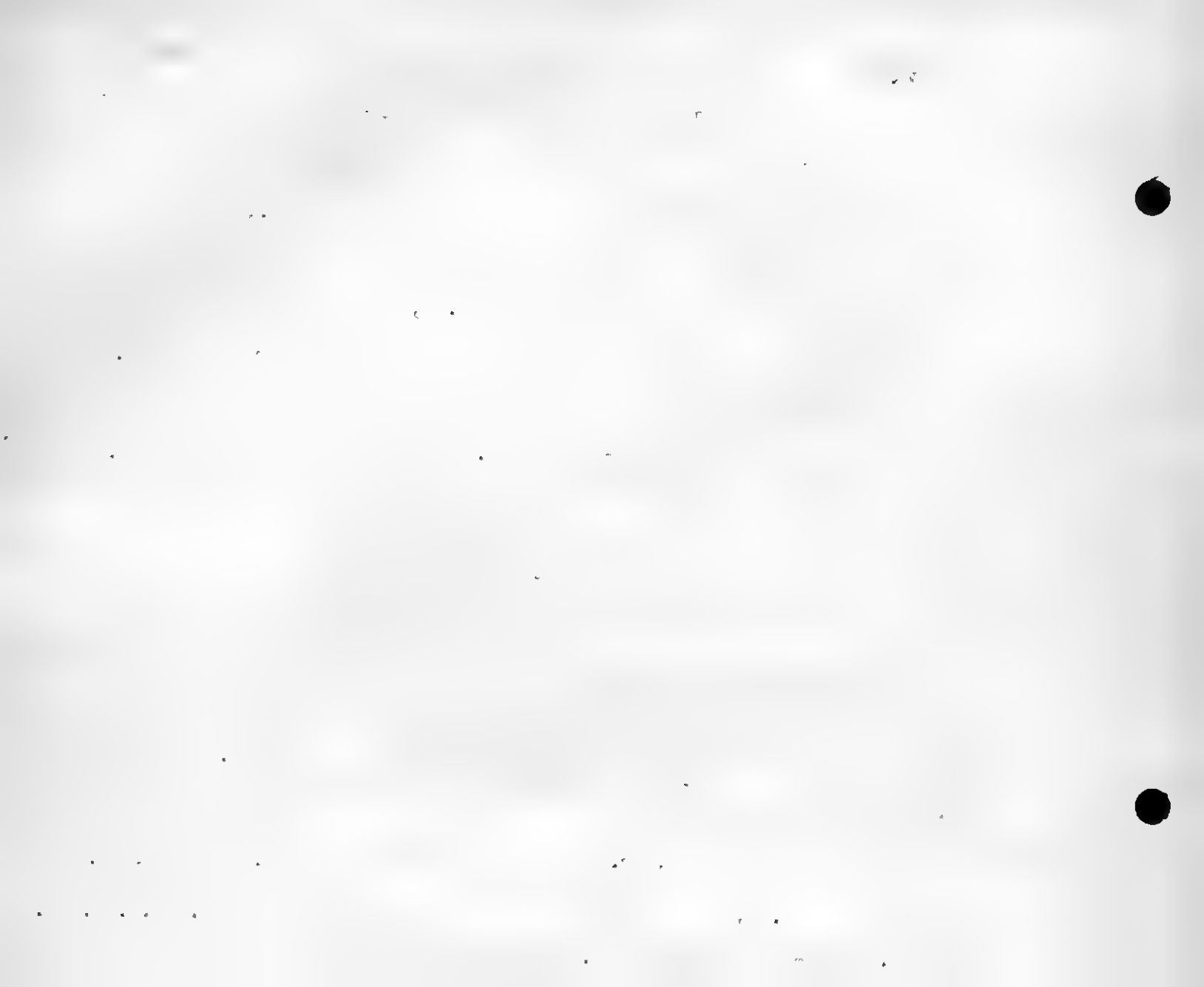
## CERTIFICATE OF DEATH

00178

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admision) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN lb <b>2 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>		d. STREET ADDRESS <b>16 Disney Ave.,</b>	
3. NAME OF DECEASED (Type or print) <b>Charles Armond SMITH</b>		4. DATE OF DEATH Month <b>January</b> Day <b>11</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 3, 1894</b>
9. AGE (In years birthdays) <b>72 yrs</b>		IF UNDER 1 YEAR Months <b>11</b> Days <b>19</b> Hours <b>67</b> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chauffeur</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Produce</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>John Lowe Smith</b>		14. MOTHER'S MAIDEN NAME <b>Laura Virgie Scheminant</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-03-8243</b>	
17. INFORMANT <b>Mrs. Gloria Taylor - 16 Disney Ave.,</b>		Address <b>Pasadena, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Malignant Hypertension</b> DUE TO (c) <b>Arteriosclerotic Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b> <b>2 yrs.</b> <b>8 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <b>1959</b> , to <b>Jan. 11, 1967</b> , that (I) <del>was</del> saw the deceased alive on <b>Jan. 11, 1967</b> , and that death occurred at <b>M</b> , from causes on and on the date stated above			
22a. SIGNATURE <b>Arthur Lankford Jr. MD</b>		22b. DATE SIGNED <b>5:30 AM 1-11-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Arthur Lankford, Jr.</b>		22d. ADDRESS <b>2934 Mountain Road, Pasadena, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan. 14, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Ritchie Hgwy., A.A.Co., Md.</b>	
24. FUNERAL DIRECTOR <b>George J. Gonce-4001 Ritchie Hgwy., Baltimore</b>		25a. REC'D BY REGISTRAR <b>J. Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		DATE <b>JAN 17 1967</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.







# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
GM 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00178

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00180

1 PLACE OF DEATH a COUNTY <u>Anne Arundel</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution, residence before admission) a <u>Maryland</u> b COUNTY <u>Anne Arundel</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie, Md.</u>		c LENGTH OF STAY IN 1b <u>12.1</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Arundel Hospital, Glen Burnie, Md.</u>		d STREET ADDRESS <u>302 Freetown Road</u>	
3 NAME OF DECEASED (Type or print) First <u>Carl</u> Middle <u>Brande</u> Last <u>Senior</u>		4 DATE OF DEATH Month <u>1</u> Day <u>18</u> Year <u>1967</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>N</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>8-3-89</u> 1888
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Re</u>		10b KIND OF BUSINESS OR INDUSTRY <u>md</u>	9 AGE (In years last birthday) <u>78</u> yrs
11 BIRTHPLACE (State or foreign country) <u>md</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>James Brown</u>		14 MOTHER'S MAIDEN NAME <u>Mary</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO	
17 INFORMANT <u>Senora Smith 282 Sally Rd</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ (c) _____			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____	20d INJURY OCCURRED Where <input type="checkbox"/> Not Where <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office, etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. H. H. H.</u>		22. DATE SIGNED <u>1-18-67</u>	
EXAMINER'S NAME (Type) <u>E. H. H. H.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>1/23/67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Halls Church Yard</u>	23d LOCATION (City or Town) (County) (State) <u>a a Co., Md.</u>
24 FUNERAL DIRECTOR <u>B. Brown</u>		25a REC'D BY REGISTRAR <u>JAN 20 1967</u>	
ADDRESS <u>108 W. Montgomery St.</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



## CERTIFICATE OF DEATH

00181

00181

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY IN 1b <u>1/14/67 to 1/19/67</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Arundel Hospital</u>		d. STREET ADDRESS <u>12711 Brunswick Lane</u>	
3. NAME OF DECEASED (Type or print) First <u>Elsa</u> Middle <u>(nmi)</u> Last <u>Stearn</u>		4. DATE OF DEATH Month <u>January</u> Day <u>14</u> Year <u>67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 29, 1902</u>
9. AGE (In years last birthday) <u>64</u> yrs		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Medical Librarian</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>State of Md.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>(unknown) Moses</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>100-16-4403</u>	
17. INFORMANT <u>Walter Stearn</u> Address <u>12711 Brunswick lane Bowie, Md</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) <u>  </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/14/67</u> to <u>1/19/67</u> , that (I) (we) last saw the deceased alive on <u>1/14/67</u> , and that death occurred at <u>1:30 PM</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Eileen L. ...</u>		22b. DATE SIGNED <u>1/19/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Frederic G. ...</u>		22d. ADDRESS <u>1115 Cedar ...</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>Jan. 16, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Crematory</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Singleton Funeral Home</u>		25a. REC'D BY REGISTRAR <u>  </u> ADDRESS <u>Glen Burnie, Md.</u>	
25b. REGISTRAR'S SIGNATURE <u>  </u>		DATE <u>JAN 15 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

00179

00182

1. PLACE OF DEATH a. COUNTY <u>HA.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Kid.</u> b. COUNTY <u>HA.</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Brooklyn.</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BR.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Y-5th Ave.</u>				d. STREET ADDRESS <u>2 5th Ave.</u>			
3. NAME OF DECEASED (Type or print) <u>E. BIG E. STEMBER</u>				4. DATE OF DEATH Month <u>1</u> - Day <u>6</u> - Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-1-86</u>	9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house.</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>W. Va.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Marconi, Ignazio</u>				14. MOTHER'S MAIDEN NAME <u>Hannah Benast</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Family Name</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pancreas of Pancreas</u> DUE TO (b) <u>w/ metastasis</u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11/29/67</u> , 19 <u>  </u> to <u>1/6/68</u> , 19 <u>  </u> , that (I) (we) last saw the deceased alive on <u>1/5/68</u> , 19 <u>  </u> , and that death occurred at <u>1:30 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>S. MURRES</u>				22b. DATE SIGNED <u>1/6/68</u>			
22c. PHYSICIAN'S NAME (Type) <u>Silvino B. Murres</u>				22d. ADDRESS <u>  </u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>1-9-68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross</u>		23d. LOCATION (City, town or county) (State) <u>Brooklyn</u>	
24. FUNERAL DIRECTOR <u>1111 E. 237</u>				25a. REC'D BY REGISTRAR <u>  </u> DATE <u>JAN 9 1967</u>			
				25b. REGISTRAR'S SIGNATURE <u>  </u>			



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>A.A.Co</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>GLEN BURNIE</u>		c. LENGTH OF STAY IN 1b <u>MARYLAND</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>N. ARUNDEL Hospt.</u>		e. STREET ADDRESS <u>527 2nd St.</u>	
3. NAME OF DECEASED (Type or print) <u>CARL</u> First <u>F.</u> Middle <u>STEPHAN</u> Last		4. DATE OF DEATH Month <u>1</u> Day <u>18</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 8, 1887</u> yrs. <u>79</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BARBER</u>		11. BIRTHPLACE (State or foreign country) <u>ROSS BACK, GERMANY</u>	
13. FATHER'S NAME <u>Herman Stephan</u>		14. MOTHER'S MAIDEN NAME <u>Emma Mueller</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>T. CARL STEPHAN #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>atherosclerosis, coronary artery disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>stroke</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>stroke</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL EXAMINER'S NAME (Type) <u>F. L. L. L.</u>		22. DATE SIGNED <u>1-18-67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1-22-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest</u>		23d. LOCATION (City, town or county) (State) <u>Annapolis A.H. MD.</u>	
24. FUNERAL DIRECTOR <u>John M. L. L. L.</u>		25a. REC'D BY REGISTRAR <u>JAN 24 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

8 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
00184											
1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>910 WELLS ST.</u>						d. STREET ADDRESS <u>910 WELLS ST.</u>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNIE REBECCA WOOD STEVENS</u>						4. DATE OF DEATH Month Day Year <u>1 2 1967</u>					
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT 25 1888</u>		9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>CALVERT CO. M.D.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>GEORGE C. WOOD</u>						14. MOTHER'S MAIDEN NAME <u>FLORENCE J. ELLIOTT</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Mrs. Marie Berec <u>MRS. KATHERINE L. SHEPHERD #2</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Insufficiency</u> 350X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rheumatoid arthritis</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>6/7</u> , 19 <u>62</u> , to <u>1/2</u> , 19 <u>67</u> , that (I) <u>last</u> saw the deceased alive on <u>1/1</u> , 19 <u>67</u> , and that death occurred at <u>11:30 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Richard I. Hochman</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>1/3/67</u>											
22c. PHYSICIAN'S NAME (Type) <u>Richard I. Hochman, M.D.</u> 22d. ADDRESS <u>59 Franklin St., Annapolis, Md.</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>1-5-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Edwards Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>ANNAPOILIS M.D.</u>			
24. FUNERAL DIRECTOR <u>JOHN M. TAYLOR SONS ANNAPOILIS M.D.</u> ADDRESS						25a. REC'D BY REGISTRAR <u>J. Charles Judge</u>		25b. REGISTRAR'S SIGNATURE			
						DATE <u>JAN 5 1967</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
00183 CERTIFICATE OF DEATH 00185										
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>M.D.</u> b. COUNTY <u>A.A.C.</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville</u>			c. LENGTH OF STAY IN 1b <u>4 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Knollwood Manor</u>					d. STREET ADDRESS <u>P.O. Box 778</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>VIRGINIA M. Scelleroon</u>			First Middle Last		4. DATE OF DEATH <u>1-13-67</u>		Month Day Year			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-8-1889</u>		9. AGE (In years last birthday) <u>77</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Elkins W. Va.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>John S. Wright</u>					14. MOTHER'S MAIDEN NAME <u>Mary Hinkle</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Nus Karl Ziegler</u>			Address <u>Above</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) <u>Gen. Art &amp; Senility</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> , 19 <u>60</u> to <u>1967</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1-11-67</u> 19 <u>67</u> , and that death occurred at <u>8 P</u> M, from the causes and on the date stated above.										
22a. SIGNATURE <u>Robert R. Hahn</u> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1-13-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Robert R. Hahn</u>					22d. ADDRESS <u>P.O. Box 73 Severna Park</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>1-18-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cem</u>			23d. LOCATION (City, town or county) (State) <u>Cumberland, Md</u>			
24. FUNERAL DIRECTOR <u>Robert S. Barranco</u>					ADDRESS <u>Severna Park, Md</u>		25a. REC'D BY REGISTRAR <u>J. Charles Judge</u>		25b. REGISTRAR'S SIGNATURE	
DATE <u>JAN 16 1967</u>										

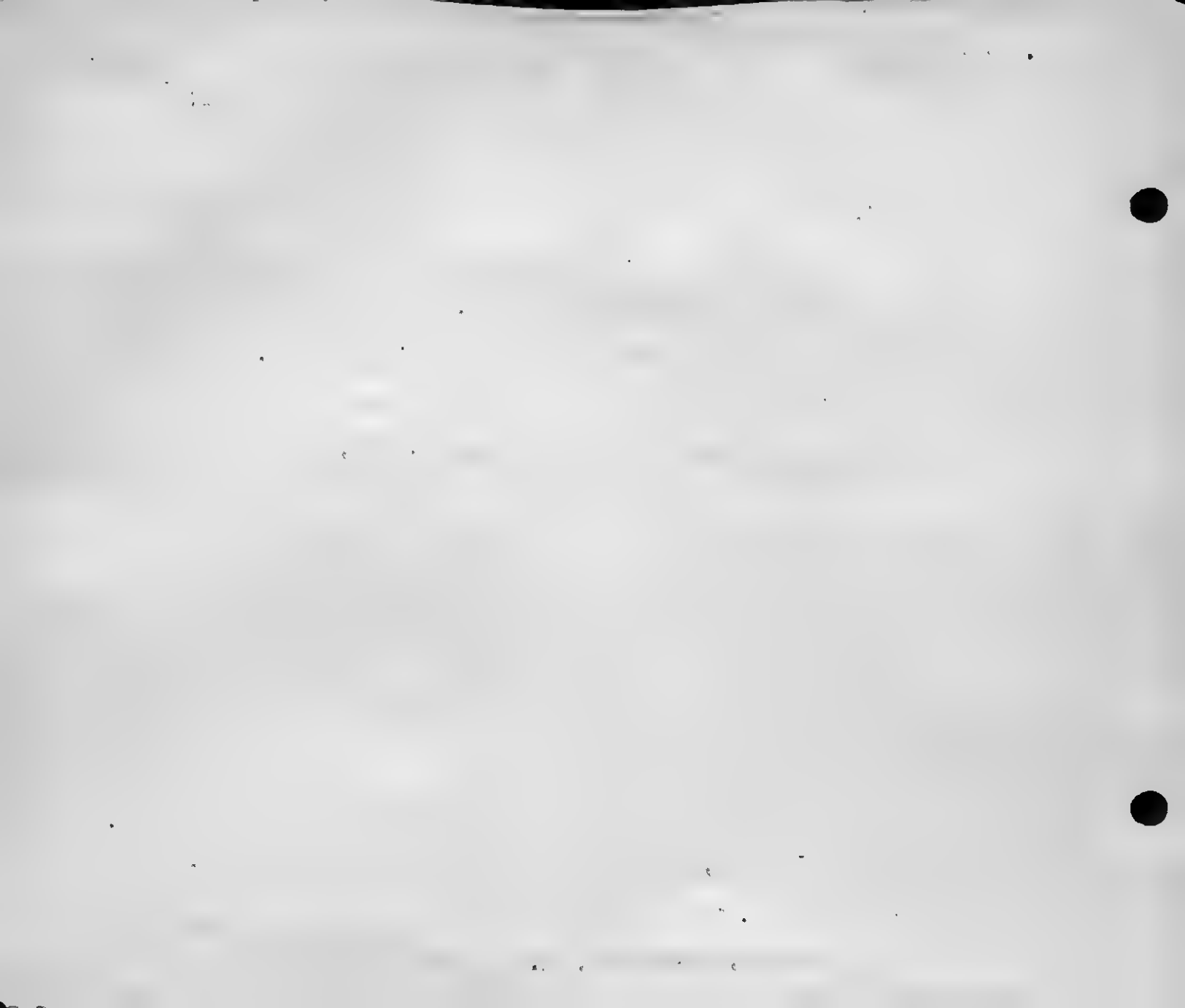


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 5-63

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00184						00186					
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>AA</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>					
c. LENGTH OF STAY IN 1b						d. STREET ADDRESS <u>Box 141, North Ferry Point Road</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Joseph</u> Last <u>Teal</u>						4. DATE OF DEATH Month <u>January</u> Day <u>13</u> Year <u>1967</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 13, 1897</u>		9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffeur</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frank Teal</u>						14. MOTHER'S MAIDEN NAME <u>Annie Hines</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>						16. SOCIAL SECURITY NO. <u>Nanie L. Teal, same as 2</u>					
17. INFORMANT <u>Nanie L. Teal, same as 2</u>						Address <u>  </u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Emphysema</u> DUE TO <u>  </u> Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (a), stating the underlying cause last. DUE TO (c) <u>  </u>										INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u>		Month, Day, Year <u>  </u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>NOV. 20, 1966</u> to <u>JAN 13, 1967</u> , that (I) (we) last saw the deceased alive on <u>JAN 13, 1967</u> , and that death occurred at <u>8:20 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>J. Brady Smith</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>14 Jan. 1967</u>		M.D.	
22c. PHYSICIAN'S NAME (Type) <u>Brady Smith, M. D.</u>						22d. ADDRESS <u>Riviera Beach, Pasadena, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>16 Jan. 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Western Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>		25a. RECEIVED BY REGISTRAR <u>JAN 18 1967</u> 25b. REGISTRAR'S SIGNATURE <u>J. Brady Smith</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Kirkley Funeral Home, Glen Burnie, Md.</u>						ADDRESS <u>  </u>					



00185

## CERTIFICATE OF DEATH

00187

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (Note: Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN lb <b>Annapolis</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>		d. STREET ADDRESS <b>305 Edgemere Drive</b>	
3. NAME OF DECEASED (Type or print) <b>CLARK JOSEPH TRAYNOR</b>		4. DATE OF DEATH January 2, 1967	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH <b>January 1, 1967</b>	9. AGE (in years lost birthday) yrs <b>7</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SINGLE</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>JOSEPH CLARK TRAYNOR</b>		14. MOTHER'S MAIDEN NAME <b>RITA MARIE CONNOR</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>#13 + 2</b>	
17. INFORMANT <b>#13 + 2</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory failure</b> DUE TO <b>Pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Pneumatury</b> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not While <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M. from causes and on the date stated above.			
22a. SIGNATURE <b>Antonio M. Rivera</b>		22b. DATE SIGNED <b>3 Jan 67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Antonio M. Rivera M.D.</b>		22d. ADDRESS <b>South River Med. Ctr., Edgewater, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>1-4-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>HILLCREST CEM.</b>	23d. LOCATION (City or Town) (County) (State) <b>ANNAPOLIS AA MD</b>
24. FUNERAL DIRECTOR <b>John M. Taylor, Sons Annapolis MD</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 5 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00186

## CERTIFICATE OF DEATH

00188

1 PLACE OF DEATH a. COUNTY <u>ANNIE ARUNDEL</u> <del>CROWNSVILLE</del> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BROOKLYN</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CROWNSVILLE STATE HOSP.</u>		d. STREET ADDRESS <u>234 EDGEVALE Rd.</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>RICHARD P. VOSLER</u>		4 DATE OF DEATH Month Day Year <u>1 - 29 - 19 67</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-11-1892</u>
9 AGE (In years) <u>74</u> yrs		10. IF UNDER 1 YEAR Months Days Hours M.in.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Serviceman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S.A.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>WISCONSIN</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>THOMAS VOSLER</u>		14. MOTHER'S MAIDEN NAME <u>MARY VOSLER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes WWI and WWII</u>		16. SOCIAL SECURITY NO. <u>214-20-3783</u>	
17. INFORMANT <u>Mrs. Ethel Vosler-234 Edgevale Rd.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u> <u>471X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CHRONIC BRAIN SYNDROME AND ARTERIOSCLEROSIS</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12-26, 1966</u> to <u>1-29, 1967</u> that (I) (we) lost saw the deceased alive on <u>1-29-1967</u> , and that death occurred at <u>7 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>1/29/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. BENEDICT M.D.</u>		22d. ADDRESS <u>Crownsville State Hospital</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2-1-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Ritchie Hwy., A.A. Co., Md.</u>
24. FUNERAL DIRECTOR <u>George J. Gonce-4001 Ritchie Hwy., Baltimore</u>		25a. REC'D BY REGISTRAR <u>DATE FEB 2 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



00187

## CERTIFICATE OF DEATH

00189

1 PLACE OF DEATH a. COUNTY <i>A. Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>A. Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie</i>		c. LENGTH OF STAY IN 1b <i>7</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>215 St. James Drive</i>		d. STREET ADDRESS <i>215 St. James Drive</i>	
3 NAME OF DECEASED (Type or print) <i>ALBERT GEORGE WALKER</i>		4. DATE OF DEATH <i>January 18 1967</i>	
5 SEX <i>Male</i>	6 COLOR OR RACE <i>W</i>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <i>9-14-1986</i>
9 AGE (In years last birthday) <i>80</i> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <i>Oxford, England</i>		12 CIT ZEN OF WHAT COUNTRY? <i>England</i>	
13 FATHER'S NAME <i>George Markim Walker</i>		14 MOTHER'S MAIDEN NAME <i>Elizabeth Osborne</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16 SOCIAL SECURITY NO <i>217-18-7744</i>	
17 INFORMANT <i>Daughter</i>		Address <i>115 St. James Drive Rt. 2 New Windsor, Md</i>	
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage</i> DUE TO (b) <i>Generalized arteriosclerosis</i> DUE TO (c) <i>Arteriosclerotic heart disease</i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>July 16, 1964</i> to <i>Jan. 18, 1967</i> , that (I) (we) last saw the deceased alive on <i>Jan. 18, 1967</i> , and that death occurred at <i>8:20 P.M.</i> from causes and on the date stated above.			
22a. SIGNATURE <i>Edmond Moushabeck</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>EDMOND M. MOUSHABECK</i>		22d. ADDRESS <i>SIG MARLEY STATION Glen Burnie, Md 21061</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <i>1/21/1967</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Taylorville Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Carroll Co., Md.</i>
24 FUNERAL DIRECTOR ADDRESS <i>C. M. Woltz Box 241 Sykesville, Md.</i>		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE <i>J. Charles Jones</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



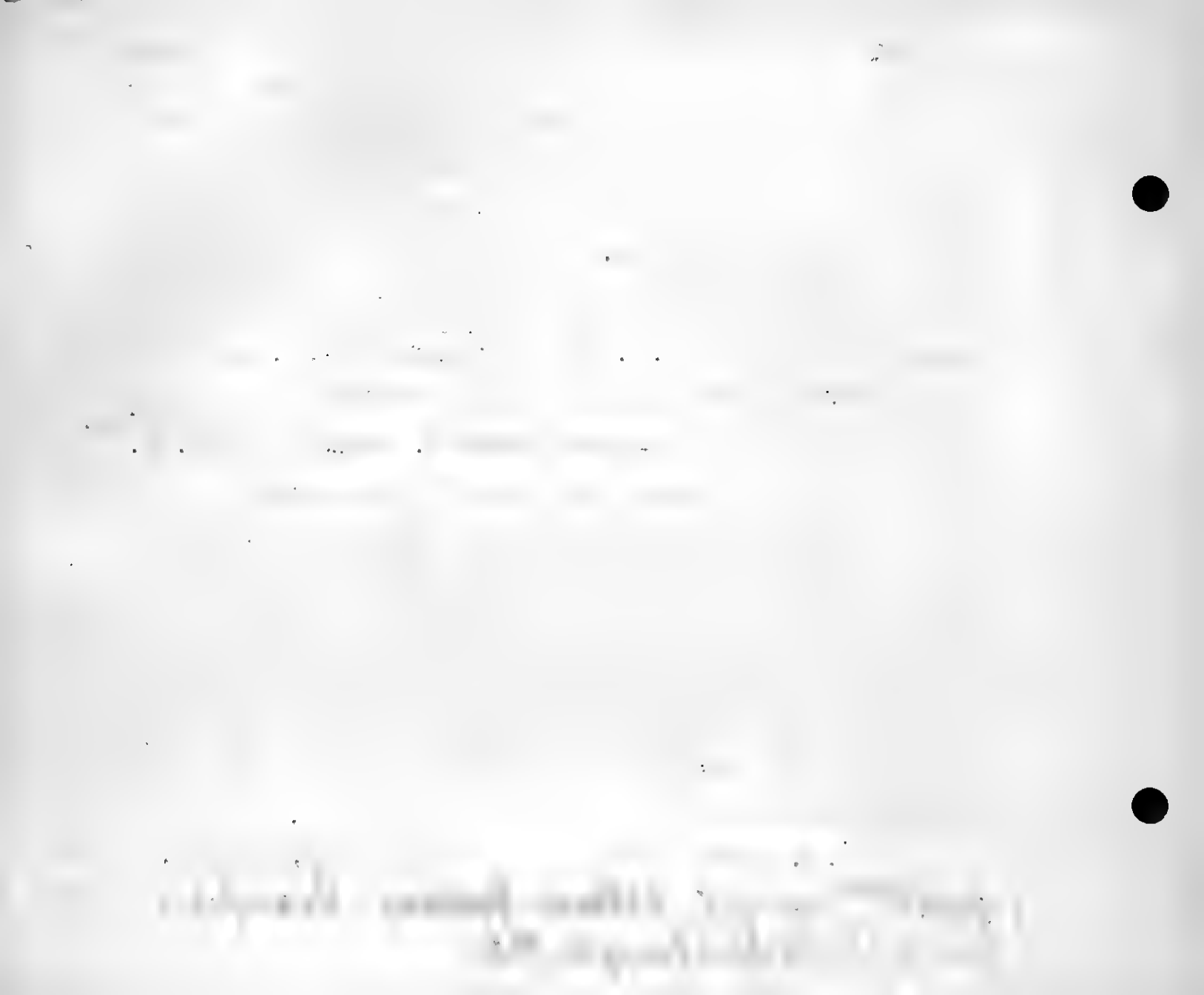
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00188 CERTIFICATE OF DEATH 00190

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS</b>				c. LENGTH OF STAY IN 1b <b>39 DAYS</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>NAVAL HOSPITAL</b>				d. STREET ADDRESS <b>504 DEWEY DRIVE</b>			
3. NAME OF DECEASED (Type or print) <b>RICHARD</b> First <b>Owen</b> Middle <b>WILLIAMS</b> Last				4. DATE OF DEATH <b>JAN 8</b> Month <b>19 68</b> Day Year			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>CAUC</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>18 MARCH 1879</b>	
9. AGE (In years last birthday) <b>87</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NAVAL OFFICER RET</b>		11. BIRTHPLACE (County & State, or foreign country) <b>PEN-Y-GROES</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>WILLIAM EVION WILLIAMS</b>				14. MOTHER'S MAIDEN NAME <b>SARAH FOOD</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>1895-1930</b>		17. INFORMANT <b>DOROTHY K. WILLIAMS</b>		18. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>27 NOV 1966</b> to <b>8 JAN 1967</b> , that (I) (we) last saw the deceased alive on <b>8 JAN 1967</b> , and that death occurred at <b>207 AM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>L. W. Johnson</b>				22b. DATE SIGNED <b>8 JAN 1967</b>		22c. PHYSICIAN'S NAME (Type) <b>L. W. JOHNSON LT USNR</b>	
22d. ADDRESS <b>NAVAL HOSPITAL, ANNAPOLIS, MARYLAND</b>				22e. REC'D BY REGISTRAR <b>John M. Paylor</b>			
22f. REGISTRAR'S SIGNATURE <b>John M. Paylor</b>				22g. DATE <b>JAN 12 1967</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE THEREOF <b>1-11-67</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>U.S. NAVAL ACADEMY</b>				23d. LOCATION (City, town or county) (State) <b>ANNAPOLIS MD.</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00189					00191				
1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS, MARYLAND</b> c. LENGTH OF STAY IN 1b <b>13 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>NAVAL HOSPITAL</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>12 MARYLAND AVE. ANNAPOLIS, MD. 021</b> d. STREET ADDRESS <b>12 MARYLAND AVE.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>EMILY H. WINTERS</b>			First Middle Last		4. DATE OF DEATH <b>JAN. 8 1967</b>		Month Day Year		
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>CAUC.</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JAN. 17, 1891</b>		9. AGE (in years last birthday) <b>75</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		11. BIRTHPLACE (County & State, or foreign country) <b>BELLEFONTE PA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		IF UNDER 1 YEAR Months Days Hours Min.	
13. FATHER'S NAME <b>FRANK PECK BASSETT</b>				14. MOTHER'S M maiden NAME <b>MARION HUGH BASSETT</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>CAPT HUGH WINTERS USN/RET DUNWOODY RD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RENAL FAILURE</b> 593X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>CONGESTIVE HEART FAILURE</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				ATTENDANT GA.		INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <b>26 DEC 1966</b> to <b>8 JAN 1967</b> , that (I) (we) last saw the deceased alive on <b>8 JAN 1967</b> , and that death occurred at <b>0607A</b> M, from the causes and on the date stated above.									
22a. SIGNATURE <b>L. W. JOHNSON</b>				M.O. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>8 JAN 67</b>			
22c. PHYSICIAN'S NAME (Type) <b>L. W. JOHNSON LT MC USNR</b>				22d. ADDRESS <b>USNH ANNAPOLIS, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>1-9-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN</b>		23d. LOCATION (City, town or county) (State) <b>BLADENSBURG MD.</b>			
24. FUNERAL DIRECTOR <b>John M. Layton Sons Annapolis, Md.</b>				25a. REC'D BY REGISTRAR <b>JAN 12 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

00187

00187

NAVY DEPARTMENT, WASHINGTON, D.C. JAN 17 1961

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REAR ADMIRAL

REAR ADMIRAL

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NAVY DEPARTMENT, WASHINGTON, D.C. JAN 17 1961

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NAVY DEPARTMENT, WASHINGTON, D.C. JAN 17 1961

NAVY DEPARTMENT, WASHINGTON, D.C. JAN 17 1961

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>A A Co</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riviera Beach</b>		c. LENGTH OF STAY IN 1b <b>12.1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>8108 Ft Smallwood Rd</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Ella</b>		4. DATE OF DEATH Month <b>Jan</b> Day <b>20</b> Year <b>1967</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>W</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb 18, 1890</b>	
9. AGE (In years last birthday) <b>76</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>8</b> Days <b>19</b> Hours <b>67</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Solomon Messick</b>		14. MOTHER'S MAIDEN NAME <b>Ella Hatton</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Family</b>		Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>170X</b> IMMEDIATE CAUSE (a) <b>Carcinoma of right breast metastatic</b> DUE TO (b) <b>9 years</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 6</b> , 19 <b>58</b> , to <b>1/18</b> , 19 <b>67</b> , and that death occurred at <b>1118</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Sidney R. Gehlert</b>		22b. DATE SIGNED <b>1/23/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Sidney R. Gehlert, M.D.</b>		22d. ADDRESS <b>4700 Pennington Ave. Balto. 26.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/24/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven</b>		23d. LOCATION (City, town or county) (State) <b>AA Co Md</b>	
24. FUNERAL DIRECTOR <b>McCully F H 237 Patapsco Ave 21225</b>		25a. REC'D BY REGISTRAR <b>JAN 24 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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